

# Syphilis in the Army

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## PREFACE.

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IN July, 1903, I forwarded to the War Office 144 pages of printed matter, published in India, regarding the urgent necessity of revising the collection of statistics dealing with venereal diseases in the Army. In September, 1903, a temporary scheme was essayed by the War Office; and in 1904, a permanent scheme ("Instructions Regarding Procedure in Cases of Syphilis," *vide* Appendix XXXV.). This present book is merely an amplification of my former work, and attempts to show the detailed working of a preventive medicine problem in the Army. At the International Conference held in Brussels, in September, 1899, Dr. Drysdale, one of the representative members for England, stated "that the history of the Contagious Diseases Acts in Hindustan shows that they have increased the amount of syphilis to an alarming extent amongst our unfortunate celibate troops." I trust that the numerous statistics consequently given in this book will show the reverse of Dr. Drysdale's statement, providing the reader does not consider, with Professor Fournier, of Paris, "that statistics are only good when they support you, but bad otherwise." The effect of preventive measures in India, from October, 1898, to date, should unquestionably demonstrate the good effect of control to all unbiassed persons. This, as primarily stated in my work of July, 1903, previously referred to, is only possible "if the sources of error in the collection of venereal statistics in the Army can be obviated. Defective nomenclature prevents correct deduction and classification. For statistical records to be valuable, the more exact diagnosis of primary syphilis and soft chancre is essential, and the occurrence or non-occurrence of secondary syphilis should be rigidly checked. The error adjusts itself, if secondary syphilis follows, since initial errors of diagnosis are thus corrected. Further, as cases of relapse of secondary syphilis, on re-admission to the hospital, swell the totals, an accurate record should be kept that they are re-admissions, otherwise the statistics of preventive measures will

convey a false impression, and ill-disposed persons can twist statistics to suit their various objects.

“Probably 20 per cent. of infecting sores are clinically indistinguishable from the non-infecting sore (soft chancre). Relapse of pre-existing disease accounts for at least 40 per cent. of the constantly sick ratio. There is a vast amount of information on this subject buried in medical history sheets. More especially do we refer to the bad effects of the symptomatic treatment of syphilis, and to the excellent effect of prolonged treatment in preventing relapse. In the past, persons who have not treated these diseases to the same extent as they are capable of being treated in the Army said they were neglected. If inaccurate record be guarded against, then neglect can rarely occur.”

The correctness of these views, written four years ago, has been fully proved by the working of the War Office scheme in Appendix XXXV.

My thanks are due to Messrs. John Bale, Sons and Daniels-son, Ltd., for the painstaking manner in which they have published this book, with all its difficult tables.

*Royal Herbert Hospital,  
Woolwich,  
October 15, 1907.*

H. C. FRENCH,  
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# SYPHILIS IN THE ARMY.

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## I.—CAUSATION AND INFLUENCE ON MILITARY SERVICE.

10 IF we recognise the cardinal fact that prostitution has always existed and unfortunately must continue to do so for all time, since it is primarily dependent on poverty, it is then self-evident that to control disease which is the direct outcome of prostitution, it becomes necessary to more effectually control all *irreclaimable* persons, and to place restraint on the secret spread of disease by women who are known as *clandestines*. Expense, however, is the chief barrier to more effectual control.

Major McCulloch<sup>1</sup> remarks:—"The years 1883-1903 show a very satisfactory decrease in the rejections for syphilis among men offering themselves for enlistment (*vide* Appendix II.), and although the short service system dates from 1870, yet the year 1883 marks the commencement of taking recruits in very largely increased numbers.

"Appendix III.—Chart 1 shows the extent of venereal prevalence in the *Home Army* from 1860 to 1904.

"Chart 2 represents the prevalence of venereal disease in India, from 1872 to 1903.

"Chart 3 shows *total prevalence* of venereal disease for the *whole Army* at home and abroad from 1879 to 1903.

"Chart 1 shows that the fluctuations of prevalence are chiefly in relation to the admission rates for *primary venereal sores* and *gonorrhœa*." The fact of relapse does not much affect the former. For Secondary Syphilis, *vide* Appendix IV.

"The Contagious Diseases Act of 1864 was limited to certain garrison and seaport towns; provision was made (1) for the detention of infected women, (2) for the punishment of brothel keepers who knowingly harboured diseased women. The Act of 1866 provided for *periodical* examination, and for the establishment of hospitals. The Acts were suspended in 1883, and repealed in March, 1886. Appendix III., Chart 4 (red line refers to *subjected*

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<sup>1</sup> *R.A.M.C. Journal*, October, 1905.

and the black line to *unsubjected* stations), shows the differences in the admission ratios for primary venereal sores in the two groups. The prevalence of *secondary syphilis* from 1860 to 1884 is shown by Chart 6.

“In October, 1873, orders were issued that soldiers admitted into hospital on account of venereal disease were to forfeit their pay while under treatment. Part of the diminution observed during 1873 to 1879 was ascribed to concealment of disease to avoid loss of pay.” Concealment is extremely rife to-day. Inefficiency in the Army, as later explained, is largely dependent on this factor, which it is possible to much more effectually deal with. (*Vide* Appendix I.)

#### INDIA.

Appendix VI. shows that since 1878 “the arrival of batches of young unmarried men under the ‘short service’ system, has been accompanied by much venereal disease owing to larger circulation of men, &c.”<sup>1</sup>

Movements of troops, however, differences in the moral tone of different units, and disease contracted in one station being debited to another, are all influences which may help to produce fluctuation in the records of disease.

The Lock Hospital System remained in force from 1865 to 1884, the system being partially suspended in 1885 and abolished in 1888.

Appendix III., Chart 2, shows “that a marked increase of venereal prevalence dates from 1885 and continued until 1895,” although a voluntary form of control (Cantonment Act, 1889) existed. The cause of the marked increase in India from 1888 to 1898, is due, I think, to the lessened control of prostitution in 1888-98, to the prohibition of registration and compulsory examination subsequent to 1895, and also to grave famine and plague commencing in 1896 to 1897. Migration, poverty, and neglect of local treatment, superimpose epidemic venereal diseases on endemic areas. This would tend to increase the virulence and general prevalence amongst the native community, which at once re-acts on troops in cantonments.

The Army Sanitary Committee, in March, 1897, acknowledged the effect of the former Acts, in India, in “checking not only the increase of syphilis but the severity of the disease itself.”

The East India Cantonment Act was introduced in October, 1897. (*Vide* Appendix XXII.)

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<sup>1</sup> Sanitary Report of the Commissioner with the Government of India, 1899.

The table in Appendix V. and Appendix III., Chart 2, shows the great diminution in venereal diseases that has resulted from controlling *diseased women*, although "short service" existed. The admission ratio fell from 536 per 1,000 in 1895 to 200·3 per 1,000 in 1904.

Increases are explained by re-admissions, greater care in detection, and influx of diseased persons. A decrease has resulted from an official circular letter—"Instructions for procedure in cases of syphilis," 1904, the *continuous* treatment of syphilitic cases, out-patient attendance, the efforts of officers by means of warnings, lectures, &c., in improving the moral tone and sobriety of the men, encouragement of games and athletics, diminution in the number of prostitutes, and by keeping them away from the neighbourhood of barracks, and the placing of bazaars, brothels and liquor shops out of bounds.

Appendix VII. shows some admission ratios amongst *Colonial* garrisons for the decennial period 1893 to 1902, and for the year 1903. Hong Kong, 441·8 per 1,000, heads the list, an increase following the repeal of a Contagious Diseases Act in 1889. The Women and Girls' Protection Ordinance was introduced in 1897, and it is said to be working satisfactorily. Good results have also been obtained in South Africa, Straits Settlement, Gibraltar, Malta, &c., by equivalent ordinances.

In the whole Army, in 1903, there was an average number of 3,554 men constantly in hospital on account of venereal disease, out of a total strength of 242,182 men; and of this number India contributed 1,568 out of a strength of 69,613.

*The Increase in India.*—"The young soldier is usually a trained man on arrival in India, has more time and money; women are more accessible, and curiosity prompts him to frequent the native quarters. He is removed from home influences, is more exposed to temptation, as prostitution is more common near barracks, and the example of comrades may often lead to sexual indulgence. In all armies foreign service is marked by a greater prevalence of venereal diseases than obtains among the home troops. Lastly, the soldier is more restricted in regard to marriage than the civilian."

#### INVALIDING.

The invaliding and deaths from syphilis in the period 1894 to 1903 are shown in Appendix VIII. Appendix IX. shows "that until 1888 the invalids at Netley, England, from venereal disease never reached 100, but then increased, until in 1897 they reached

804, not very far short of one third of the total invalids. This points to an increased severity of disease, as these men are considered unfit to remain longer in tropical climates."

In India, the residence period of one to five years, and especially three to four years, had the largest proportion of invaliding for venereal disease, *vide* Appendix X. For the reduction of invaliding from India, as the result of control and continuous treatment, *vide* Appendix IX. (a). For the reduction throughout the Army generally, *vide* Appendix IX. (b).

The type of constitutional syphilis at Aden in 1896-7 was, in the writer's knowledge, most severe. There were many cases of malignant syphilis, of tertiary ulceration, of iritis, and coincident scurvy. No form of control existed, and although the climate is bad, it could not be fairly considered the cause of initially severe or early malignant manifestations. These, I am of opinion, are due to virulence of the inoculated virus, no doubt accentuated by lessened resistance on the part of the individual, and aggravated by climate.

Appendix XI. shows a reduction of disease at Aden as the result of control.

Deesa (India), Appendices XIX., XX., XXI., show the marked reduction of *freshly-contracted* venereal disease as a result of control in a period known to the writer.

Mhow (Central India) contains a garrison of 2,000 British troops. Near to it is Indore, a native city of 70,000 people. Mhow has always been noted for the prevalence of venereal disease and of enteric fever. The Cantonment bazaar at Mhow contains 22,000 persons. The type of syphilis in 1898, when rupia, gummatous ulceration, and tertiary disease were frequently observed, was to the writer's knowledge more virulent than in the latter part of 1899 or in 1900. From April to July, 1900, however, the daily influx of some 500 famine-stricken persons caused virulent forms of venereal disease, as previously explained. The year 1899 (control in existence) shows 452 admissions as contrasted with 1,360 in 1894 (absence of control) (*vide* Appendix XII.).

*Freshly-contracted* venereal disease was, to my knowledge, less prevalent at Kamptee in the *hot* weather (April to June in 1900, and the same months in 1901) (*vide* Appendices XIII., XIV.). Appendix XV. shows the effect of control.

The prevalence of venereal sores and gonorrhœa is the index to the early effect of control, and of the work of local authorities; and the prevalence of syphilis is the best index to the ultimate

effect of control. If the syphilis ratio, however, is unduly high, as contrasted with the ratio for non-infecting ulcers (soft chancre), this points to two things: first, more accurate diagnosis, and secondly, concealment on the part of soldiers and treatment by chemists, who cure the soft chancre, but are unable to cope with syphilis. This partly explains the great frequency of inflammation of the inguinal glands, due to initial concealment or ineffectual treatment. The causation of this common condition amongst soldiers is often very difficult of recognition, and so the statistics of venereal diseases may be vitiated.

“As youth and recent arrival have become more common in the Army, venereal disease and enteric fever have not unnaturally increased in frequency of occurrence” (*vide* Appendices VI. and XIIa.) “Ague and venereal diseases are the chief causes of admission, and enteric fever and hepatitis the chief causes of death, in the European Army in India”<sup>1</sup> (*vide* Appendix XVI.).

In India syphilitic fever, and urethral fever from gonorrhœa, may not uncommonly be confused with ague in the absence of a microscopical examination. If all cases of syphilis complicated with ague were recorded as malignant syphilis, in accordance with Professor Fournier's views, it would be found that in India in at least 20 per cent. a soldier has suffered, or is suffering, from the dual poison. At Mhow, in 1900, I saw twenty men invalided for syphilis, and five of these men could equally as well have been invalided for profound malarial cachexia, but never suffered from *malignant* syphilis as ordinarily understood by the term. By “malignant” syphilis is ordinarily meant the occurrence of destructive lesions, tertiary in nature, within the first six months or so.

*Native Troops in India.*—Venereal disease is ten times greater amongst British than amongst Native troops (*vide* Appendices XVII. and XVIII.). The Native soldier is usually married, remains four or five years in the same place, knows the country, and usually associates with better-class women than the British soldier. Further, he is under a *long* service system, and is, consequently, not so subject to some of the factors that tend to increase the incidence of venereal diseases amongst British troops.

The annual invaliding and death ratios for venereal disease, however, are excessive amongst Native troops, and we are justified in assuming that many cases must be severe, concealed, or untreated. Out-patient treatment should be more systematically practised amongst Native troops.

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<sup>1</sup> Sanitary Report of Commissioner with the Government of India, 1899.

## II.—PREVENTION.

The Secretary of State for the Home Department was approached in 1896, with the object of appointing a Departmental Committee. The Government did not think the time had arrived for taking action in the matter, because there was not then a “sufficiently informed public opinion” on venereal diseases to justify them in so doing.

The British Medical Association, in 1899, proposed a Departmental Committee to enquire as to the prevalence and *treatment* of venereal disease, the number of beds available, and to collect suggestions.

In accordance with the Towns Clauses Act of 1847, the police may interfere if a prostitute accosts passers-by in the street, or causes any scandal in a street, restaurant, &c., and can take action if two ratepayers complain, on their own responsibility, after having given a caution.

As diseased persons are not obliged to undergo treatment in a hospital, syphilis shows itself in Great Britain in a much more severe form than on the Continent. In Brussels, these forms are known as *English syphilis*. Diseased women find their way from the Continent to England, and enjoy uninterrupted personal liberty.

A Royal Commission, in 1870, reported that “We are satisfied from the evidence that the *frequent examination* of women is the most efficacious means of controlling the disease.”

At Paris, Berlin, &c., it is well known that five times out of six, syphilis originates from *clandestine* prostitution.

“It must be admitted that whenever the State places insuperable restrictions on marriage, it must be responsible for the consequences; this applies especially to the *military* and *naval* services.”

### PREVENTION IN INDIAN CANTONMENTS.

Preventive measures are primarily dependent on police control and regulation of the immigrant population, and only secondarily dependent on medical administration. A thorough knowledge is essential, however, of the customs of the people. We select India because control now exists, and over 70,000 troops are stationed there.

#### *Classification of Native Prostitutes in India.*

<i>a</i> Public	{ 1 Better class.
	{ 2 Low class.
<i>b</i> Private	Clandestine.

(a—1) *The better-class prostitutes* are dancing girls, who sing and dance at native entertainments (“nautches”), and who rarely, if ever, associate with Europeans.

(a—2) *Low-class prostitutes* are those women who have no occupation, whose husbands have died, or who have deserted them. They associate with Europeans and Natives, and frequently maintain men who act as procurers. The women, as a rule, are shameless and quarrelsome. The money earned is spent on dress, jewellery, drink, or opium. The older women not infrequently conceal diseased prostitutes arriving from a distance.

(b) *Clandestine prostitutes* are women who are employed as ayahs by married officers and soldiers, and are usually the relatives or wives of native servants employed in the patcheries, (European married quarters), barracks, or syces’ lines. Some of them (“Moorlees”), are obliged to lead an unmarried life, as devotees of a goddess of the Hindus. These women waylay soldiers after dusk on their return to barracks, or are first brought into contact with them by their husbands and relatives. Other women maintain boys to bring soldiers to them ; or in the evening go in tongas outside cantonment limits, or, in the day, go to the jungle under the pretence of collecting materials for cow-dung cakes, which are used as fuel. A common practice of the soldier in India is to go, as he calls it, “jungling” ; and a shooting pass often entails a visit to hospital.

Like cholera, venereal diseases follow mercantile tracks ; and so the general trend of prevention is indicated.

The rules in the Cantonment Code, 1899 (Appendix XXII.), are most excellent, if only they are properly understood and *efficiently* carried out by the four individuals chiefly concerned : the doctor, the magistrate, the general, and the soldier. The latter, however, is the weakest link in the chain, as he seldom has any wish to assist. If the chuckla quarter in the bazaar that he frequents were better lighted, and the houses numbered in accordance with paragraphs 86 and 87, Cantonment Code (Appendix XXII.), it would then be more easy to trace the person from whom disease has been contracted. The fact, however, of solicitation in or about Cantonments makes it a difficult matter to entirely stamp out disease without more stringent restrictions to prevent *clandestine* prostitution. A sense of romance, or of safety, makes the man prefer mendicants and loiterers on the roads, hill women, or those in neighbouring villages who pose as *married* women, and not as prostitutes. If early measures are taken against women beggars, much good would result, but it is

quite impossible for the medical officer to issue notices on such persons because they are migratory. Paragraphs 208 and 210, Cantonment Code (Appendix XXII.), provide for them, but in my experience the Military and Native police seldom give any real assistance. Further, any native man who is caught introducing the soldier to a woman hidden in the vicinity, should be severely dealt with by the Cantonment Magistrate. It would be useful to make every native loiterer account for himself, or ensure that he, or she, is provided with an address outside the cantonment, since cantonments are ostensibly made for British residents. The rules framed in paragraph 207, Cantonment Code, for the passage of pilgrims and others by certain routes, are most important. It would be well for the sake of clearness, that the rules referring to prostitution should be placed in the Cantonment Code in some such order as given in Appendix XXII.

The Cantonment Magistrate and Medical Officer should act together, but at present it is the Medical Officer on whose sole responsibility a notice to attend for inspection is served. Procedure, however, must be definite to a degree, and if Medical Officers take the initial responsibility, let them be invested with Magisterial authority, allow them to deal altogether with the women, and let a certain number of police be directly under their control and directly responsible to them that diseased and evicted persons do not re-enter cantonments. The dual authority of Magistrate and Medical Officer, since it involves frequent reference between them, must be uncertain in action under the best auspices, but especially so in India, in matters of this kind.

Constables could keep a watch on all women without occupations who are proceeding to and coming from barracks, and in the bazaar. If a woman is found *clandestinely* practising prostitution, she should be warned or removed from the cantonment. At Deesa, from April to July, 1899, venereal disease, though previously rife, was practically stamped out. During this period there were only eight cases of "freshly-contracted" venereal disease among 1,250 British and native troops (*vide* Appendix XX.). No assistance was given by the native police. In this good result, however, the Medical Officer was aided by the Political Resident of the adjoining native territory, where the Cantonment Act is not in force, and where the diseased women come from. Similarly at Mhow, from April to October, 1900, the police took little interest in the matter (*vide* Appendix XXXIV.). Military police constantly changed are fairly effective, but a couple of selected native Medical Subordinates specially employed

in the bazaar under the Medical Officer, would be more useful, as native police sent with soldiers to identify women commonly meet with ridicule. It is difficult in the day to recognise a woman seen by night, and the young woman may be concealed, and an old woman resident in the house identified. Native soldiers, however, with more guilt may deliberately point out women who have rejected their advances. In the latter event, the Cantonment Code, 1899, does not assist or safeguard a Medical Officer much in conducting such responsible work. The fact that a woman is diseased does not necessarily prove that the man contracted it from her. The fact that the man is diseased and not the woman, does not prove when he reports her that he may not have acted in perfect good faith in the belief that she diseased him. Is the Medical Officer to be called on to give to others the source of the evidence on which he ordered her for examination, and what procedure should be adopted. At one station, 47 diseased men identified 37 public prostitutes of whom 30 were found free from disease. On the other hand, out of 50 women *privately* soliciting 48 were found diseased. As a rule, the latter class were newly-arrived in the cantonment, of beggar caste or paupers, totally destitute, and extensively diseased. The *clandestine* prostitute has to make herself known, and is, consequently, more dependent on solicitation than the irreclaimable woman. A most important thing is to curtail the number of prostitutes in a cantonment, a difficult but quite feasible task. Prostitutes are constantly re-infected by diseased native men, over whom at present there is not any real control exercised. It would be useful to medically inspect the lower-class immigrant male population, to punish those persons concealing or transmitting venereal disease, to obtain the help of native practitioners, and to enforce notification. Women are often quite unaware that they are diseased, yet there is a penalty attached to the fact of disease; but every man knows when he is diseased, and is not punished when he transmits it.

The effectual registration and localisation of irreclaimable prostitutes in military cantonments need not necessarily increase vice; unless it is considered that the fear of contracting disease increases self-control, which experience clearly demonstrates is not the case. Many lower-class men in India, as in Europe, live on the private immorality of their women, and even marry with this object in view. Well-directed control can direct women back to the paths of virtue. This, and the reduction of disease, are the two primary aims of all Continental legislation and registra-

tion, and these aims are usually attended by marked success as regards rescue work. The State can never sufficiently control *individual* morality nor the poverty on which prostitution is mainly dependent.

The money grant for this special work should be distinct, accurately apportioned, and under the direct control of the Principal Medical Officer of the District. This is not the case at present, *vide* paragraph 201, Cantonment Code, 1899 (Appendix XXII.), and the Cantonment Magistrate can fill the beds with famine, police, or pauper cases. The Medical Officer is responsible that the money grant is not exceeded, whilst others fill his hospital with chronic cases not suitable for admission, which militates against individual initiative, or leads to friction.

Methods of prevention can only be ascertained by experiment, and prolonged experience over small areas at first, and then over gradually increasing areas. All adverse factors due to chance local circumstances must be eliminated, as far as possible, by enquiry from local, medical, or other opinion. It is necessary to be assured that there is no disease remaining by the more efficient medical inspection of *both* men and women, and by their temporary segregation for a few weeks when suffering from local lesions about the pudenda. If we exempt certain individuals from inspection, or from segregation, we must ensure that a penalty attaches to the act of transmission of venereal diseases to others, and to the fact of concealment. Such legislation already exists in some countries. Due care must be taken that exemption does not render our other efforts ineffectual. As R.A.M.C. Officers necessarily look after the men suffering from venereal affections at the Station Hospital, they should also, I think, have charge of the Cantonment Hospital for diseased women rather than an I.M.S. Officer, as they could thus get to know both men and women, and so obtain valuable information as to diseased persons. European supervision, in India, is the most trustworthy, be it for plague, famine, or prostitution. It is necessary to pursue a rigorous protective policy against pauper immigrants, and this necessitates more efficiently performed medical inspection. The police must be efficient, paupers provided for, and mendicants removed. This is not the State regulation of vice, but suggests a method of State control of disease, affording, when properly safe-guarded, a possible road to virtue. It is also necessary, I think, that local authorities in India should *use* their authority, and, by more freely exercising it, make themselves more conversant with their power. The

somewhat convenient shelter of public opinion, under which local authorities are at present too apt to take refuge, must be removed by more clearly defining what the public health demands. This would tend to check inertia, which is fatal to any scheme. Public opinion should be based on common sense and governed by rational hygienic laws—"the good of the many." Such were the sanitary laws of Moses in Leviticus, and their lasting effect is evidenced amongst Jews of the present day, "amongst whom syphilis and alcoholism are such rare diseases as to call for comment. The Jews consequently thrived amongst alien nations, except when they adopted the habits of these nations." The English Army in India, owing to its isolation, is in a somewhat analogous position, but one fact is apparent, that the prevalence of the worst forms of venereal disease in India, is largely preventable. Good results, however, are often dependent on *individual* exertion, and this factor in control was fully recognised at the Brussels International Conference on Venereal Diseases in 1899.

Venereal diseases are not like other contagious diseases, since a person attacked is for a much longer period a source of danger to the community. He or she remains silent and conceals the disease owing to an innate sense of shame. Such concealment militates against notification, unless voluntary and private in nature.

If, in the case of women discharged from a cantonment, the police were punished when these women openly return, such a procedure, it is believed, would have a stimulating effect on non-zealous policemen, and act as an effective counter-irritant to the bribery which is necessarily rampant amongst oriental police. If only the number of inhabitants in cantonment bazaars were kept within proper limits, the expenditure on preventive sanitation generally would be much lessened. When the work of a cantonment hospital is done on regular lines, a measure of success is early achieved, otherwise there is failure. Especially is the latter result liable to occur with a defective establishment, or when an over-worked Cantonment Magistrate is left to grapple with a problem of preventive medicine which, under the best auspices, he can only imperfectly understand. In a cantonment hospital, each person employed under the Cantonment Act must be trustworthy, hard-working, considerate, and must realise the gravity of the work. A native subordinate stated "self-respecting men are not always willing to take this sort of duty, owing to the cause of becoming a laughing-stock of the population." The

chuckla is the quarter in the bazaar to which prostitutes naturally gravitate, since house property elsewhere depreciates in value by their occupation. Here they often pay enhanced rents. The women residents of this quarter materially assist in giving information as to new-comers, as it is naturally to their own interest to do so. The fact that native prostitutes (like European prostitutes) are obliged to live in certain localities, should guide the cantonment authority in preventing their changing their address within the cantonment unless willing to give up their mode of life. If they relapse, they should be removed from the cantonment. This is a police and not a medical matter. This localisation of prostitution, therefore, is a most valuable factor in the prevention of disease in any place, and control, to be of any real value, absolutely hinges on it.

With reference to European soldiers in India, strict watch should be maintained to prevent them from associating with low-class native men, who court their society with ulterior motives in view. Native male cooks in barracks commonly act as procurers for the men. That portion of the native establishment which is under the control of officers commanding corps (such as women grass-cutters of Cavalry and Artillery, bazaars in connection with European regiments, ayahs, servants in the European patcheries (married quarters) and their relatives, is scattered broadcast over the cantonment. These persons should live in the "Regimental" bazaar, which, if properly regulated, would be under more efficient sanitary control, and disease of all kinds could be thus more easily detected at its source and stopped. The area of a *Regimental* bazaar is much more limited than the Sudda bazaar, and so immigration could be much more easily checked. Paragraph 175, Cantonment Code, 1899, prohibits the residence of public prostitutes in a Regimental bazaar, in which case the clandestine prostitutes already resident there should be examined, dealt with, or evicted. Whenever disease is unduly prevalent, and in order to check clandestine prostitution and solicitation, Officers Commanding Corps could periodically detail military police with a reliable Non-Commissioned Officer to watch the roads leading to and from barracks for a distance of half a mile, especially near nullahs, bridges, and vacant compounds. This is already done in some stations, but could be more universal. The work should be well supervised. One man could be detailed to overlook the syces' lines, or Regimental bazaar. Another to exercise a general supervision over ayahs, and other female servants who are not residing in barracks. A roll of these women could be kept, with

a strict record of their characters. The native chowdries and muccadums of Regimental bazaars should be held responsible for the good order of their respective bazaars and horse lines, bringing to notice at once any suspicious characters. Ayahs, native servants, and all those persons who at night ordinarily reside outside barracks, should not be indiscriminately allowed to leave the patcheries, or enter military lines after dusk up to 9.30 p.m. without a pass, or the cognisance of their masters or mistresses. These women should be seen out of barracks, or conducted to the Regimental bazaar. The important hours, however, are from "retreat" to "lights out," when soldiers and the native female population "walk out." If bazaars in certain up-country stations other than Regimental bazaars, were placed out of bounds when venereal diseases reach a certain percentage amongst the troops, much good, it is believed, would at once accrue, as it is possible to regulate the growth, to prevent prostitution, and to limit disease in properly supervised Regimental bazaars, but owing to the constant migration and the large size of Sudda bazaars and native cities, control in the latter is well-nigh impossible under existing conditions. At present bazaars are usually only put out of bounds for cholera, small-pox, and plague.

The Commander-in-Chief in India, in his circular letter No. 425, of 14th July, 1897, lays stress on the following method of prevention:—

"Where local circumstances render it desirable, disciplinary restrictions should be put in force to prevent soldiers frequenting areas where venereal disease is known to be rife."

The annual report of the Sanitary Commissioner with the Government of India clearly indicates the particular stations where venereal diseases are prevalent. In my experience totally insufficient disciplinary restriction is enforced to discourage men from going to these large towns. A man who has been in hospital for venereal disease, should, as a routine matter, be debarred from going to the bazaar for a definite period, as men whilst actually under treatment for syphilis often get severely ill from contracting gonorrhœa, or fresh venereal disease. The uncontrolled growth of the average cantonment bazaars makes them almost as bad at the present time as the large towns. Their growth should be restricted if it is desired to make a financial saving by effecting a reduction in disease of all kinds. Fifteen or twenty years ago, when cantonment bazaars were smaller, the prevalence of venereal diseases and enteric fever was much less (*vide* Appendix VI., 12 (a)). Men on detachment

duty at small places like Fort Sitabuldi near Kamptee, or at Indore, near Mhow, almost invariably suffer from more venereal disease than men at the Headquarters of the Regiment, owing to the proximity of such places to large native cities. The disease is often of a worse type, as it is more commonly concealed.

It appears to be impracticable for the State to extensively grant to those British soldiers who have not the "gift of continency" a natural preventive of prostitution, which is marriage. It is nevertheless a question for consideration, whether the invaliding and loss of service caused by venereal diseases might not by this means be sensibly lessened, and so compensate in great measure for the expenditure entailed, and at the same time render foreign service more popular. Experience shows that when *married* men contract syphilis, it is usually when the wives are off the strength. "The short service system, the loss of European women's society, and climatic conditions, markedly predispose to venery in India." It would further appear that efficient *discipline* and *medical treatment* is the key-note to success within the Army, if the immigration of the pauper and prostitute classes is also adequately controlled in the cantonment, either by the removal of, by the segregation of, or by the frequent examination of, diseased prostitutes.

"At some stations<sup>1</sup> benefit was derived from the bazaars having been placed out of bounds on account of plague, but this result was neutralised by the women coming from the bazaars to meet and solicit the men. At other stations, moral influences were tried with varying success."

Sexual excess and the ill-effects of venereal disease are, without doubt, increased by intemperance, and, however good a man's nature may originally be, alcohol temporarily paralyses the reason, increases sexual desire, and dulls the faculties. This necessarily prevents a proper appreciation of the dangers incurred and impairs the sense of right and wrong. The medical officer at Calicut<sup>2</sup> is of opinion "that the new messing regulations, whereby the men become possessed of a lump sum of hard cash, encourage venery and increase disease." The writer can state from repeated enquiry, that the date on which the soldier too commonly admits the fact of connection, is often pay-day, or when in receipt of a bounty, &c. A certain set of men spend the evening in toddy shops, or in brothels in the bazaar, which are often under the same roof. At Mhow, the writer discovered three

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<sup>1</sup> Sanitary Report of Commissioner with the Government of India, 1899.

<sup>2</sup> *Ibid.*

houses in one street, in the prostitute's quarter of the bazaar, where the mineral waters supplied to soldiers were obtained from natives, whose factories had been previously placed out of bounds. Enteric fever in India is, in many instances, contracted near brothels in some such manner. I possess notes of several cases where enteric fever has directly followed on after gonorrhœa or syphilis in hospital, and the number of cases on record must be very large. It can be observed on medical history sheets that many men have an entry for venereal disease and for enteric fever. This usually means that the man's habits take him to the bazaar, where he is likely to contract one or other disease. (*Vide* Appendices VI. and XII. (a))

It is questionable whether the hospital stoppage does not largely defeat its own object by tending to keep men out of hospital. Some men, on being questioned, admitted that this was their reason for not reporting sick. Other soldiers are commonly treated in the bazaar, or treat themselves with Clarke's blood mixture, and come to hospital later with poisoning from the iodide of potassium contained in this mixture. They thus avoid loss of pay, and retain prestige amongst their comrades; but are insufficiently treated, and, owing to this initial concealment, are inefficient for a much longer period. A case was recently admitted to hospital with phosphorus poisoning as a result of a soldier treating himself in barracks for syphilis with phosphorus pills. He told his Commanding Officer that it was mercurial treatment at the hospital, but the records clearly showed this to be a false statement. The money accruing from the hospital stoppage should, I think, be utilised in some alternative manner in rewarding those healthy men remaining in barracks, whose self-control directly benefits the State.

Soldiers should not be indiscriminately punished. The new order in the pay warrant in regard to a loss of service pay when in hospital with venereal disease, will promote concealment unless medical inspection is much more drastic. The men can now be reduced from the first to the second class rate of service pay when inefficient from the above diseases. In some regiments soldiers on discharge from hospital make up the guards and duties they have missed, but men under mercurial treatment for syphilis should not be unduly exposed in cold weather. A certain set in every regiment not only require some check in their own interest, but also in that of the corps, and of the service. Drunkenness, which results from an absence of self-control, is punished; why should excessive sexual indulgence, which, under

short service conditions, causes a considerable loss of service, be unpunished? This is more especially applicable to the Army Service Corps, where men enlist for two years with the colours, and who are also highly paid. The hospital stoppage should, I think, be abolished, and a sliding scale of fines, as for drunkenness, established, but this is only possible by inspection and the exercise of a rigid discipline for concealment. A habitual drunkard is soon disposed of in the Army, but in the case of the more incapacitated syphilised man his comrades do the work, the State pays the bill, and invaliding for this, or other disease, is too often a question of time, climate or active service. In India, a constantly sick loss of three regiments from venereal diseases in 1897, and 660 invalids from these diseases, necessitate more thorough and drastic measures from the point of view of the State, as a trained soldier landed in India costs £100. A man who has been constantly in hospital with venereal disease, but fit for duty in other respects, should not be allowed to go to the Reserve until he has completed his contract with the State and made good his service with the colours. Men should not, I think, be passed fit for the Reserve who are suffering from recently contracted syphilis, as no means of adequately treating them at present exists in the Reserve or Militia. The encouragement of thrift, the non-issue of lump sums of money, and counter-attractions in barracks, especially on pay-day, would indirectly prove beneficial.

The advice given to drafts of *young* soldiers arriving in India from England regarding venereal disease, should be supplemented by disciplinary restrictions in the case of those men who immediately contract it (*vide* Appendix I.). At the present time a premium may be indirectly set on immorality, by the mere fact of invaliding. Such would appear to be an encouragement to young soldiers to contract and to neglect acquired disease. Many of these cases are yearly sent to the hills in the hot weather to the exclusion of more deserving men. They later show their gratitude to the State by contracting fresh disease at hill Stations, or on the return journey. Such men, or those who arrive at a station from furlough, or otherwise, with *freshly-contracted* venereal disease, require disciplinary treatment. Men also commonly conceal venereal disease prior to going on furlough and return extensively diseased. This often causes the most severe cases of syphilis, and those associated with complications, or albuminuria. The time spent in hospital may be three months to a year instead of a few weeks, and invaliding is not infrequent.

Soldiers should be closely inspected for venereal diseases prior to going on furlough, but this is not the regulation at present. In India, a certain set of men notice that hot weather spent in hospital for venereal disease is preferable to duty outside, and well-conducted soldiers in barracks consequently suffer. Games and "walking out" parades are in vogue in some regiments, to prevent the solitary walks in the bazaars for "shopping" purposes.

In addition to the State control of prostitution, the discipline in Continental Armies, the lower rate of pay, the treatment whilst confined to barracks, and punishment only for concealment, is supposed to account for the very slight amount of venereal diseases in those Armies as contrasted with the English Army in India, or in England (*vide* Appendix XXXII.). The prevention of venereal diseases, however, does not begin, continue, and end with the Medical Authorities. Much can no doubt be done at the various hospitals, but increased effort outside it would very materially diminish the necessity for much too frequent admission into it. Candidly speaking, I have not observed that a proportionate interest in the subject is observed by Officers of all ranks or Corps. This state of things is probably the result of the non-recognition of the extreme importance of the subject from a military, as well as from a financial, point of view.

Commanding Officers could promote or reward men, otherwise eligible, whose medical history sheets, over a fixed period, do not show any entry for venereal disease, and thereby directly set a premium on morality. A clean medical history sheet, from the point of view of efficiency, is as important as a clean defaulter sheet. This involves, however, more thorough medical inspection and supervision, and active, not passive, co-operation between the Regiment and the Hospital Authorities. Rewards would not only be advantageous to the State by causing increased efficiency and by reducing expenditure on hospitals, but would also directly act as incentives to self-control. These rewards would also promote a more healthy tone amongst the men, and would tend to engender contempt and not sympathy for the comrade whose good-fellowship is shown by going to hospital and thereby increasing his friend's duties. Certain young soldiers report sick with venereal disease with a smile, with an air of having accomplished something meritorious. This could be largely prevented by the posting of notices in the barrack-room in regard to the danger of venereal and other diseases, and the promise of

punishment only for concealment, or for contracting fresh disease whilst already attending hospital for venereal disease. The soldier cannot then make the excuse that he did not know. Reading the Army Act once in three months is quite ineffectual. It might be read more often to a Company if concealment occurs in that Company.

Deputy-Inspector-General E. F. Mahon, R.N., recommends "the encouragement of early marriages by offering pensions to the widows of seamen. Further, that the money saved by the non-enforcement of the Contagious Diseases Act be directed to this purpose. That pensioners in good health, who are not suffering from the sequelæ of venereal disease, be given preference for employment in Civil Establishments in the Admiralty, and such preference extended to their children." These advantages, with modifications, might well be extended to the Army, and the total amount of disease reckoned according to the number of admissions to hospital for *freshly contracted* venereal disease. An entry could be made on discharge documents, the information being extracted from the medical history sheet. Concealment of disease when reported should be assessed as equal to two ordinary admissions, as the resulting inefficiency is so great. The fact that one man may be systematically vicious and never get disease is immaterial, as such cases of exemption are quite the exception. The 7 per cent. of private soldiers allowed to marry on the strength could be given preference, according to the fact of freedom from venereal disease after three years' service. No man should be allowed to marry whilst under treatment for syphilis. The Medical Officer, however, is commonly not informed of the man's intention, and even if he were informed, could he prevent it? A remission of hospital stoppages when sick with other diseases, in the case of men free from venereal disease for a certain length of time, would be popular. Good conduct badges might be given in selected cases. To the average individual, an ounce of present gain is worth a pound of prospective advantage. If the State be regarded as the scales, and venereal inefficiency and money the commodities to be weighed, the present excess hospital and invaliding expenditure on venereal disease could be largely made a matter of adroit adjustment. The balance would, I am certain, favour the State financially, and increased efficiency be obtained. It would be well to conduct a definite enquiry on these lines.

*In the British Army.*—"Men are medically inspected before embarkation. Special venereal inspections are held :—

- “(1) The day after embarkation.
- “(2) The seventh day at sea.
- “(3) The day before disembarkation.
- “(4) On arrival at a new station.

“(5) Surprise inspections by medical officers when it is supposed that disease is being concealed.” (Very valuable, but very rarely done. Thorough surprise visits should be made to one company at a time, and whenever a soldier reports sick with “concealed disease,” his company, or battery, should, as a routine matter, be rigidly inspected for other cases.)

“The venereal inspections, in the opinion of many officers, are very much objected to, both by medical officers and well-conducted men, and it has been questioned whether the good they do is not more than counterbalanced by the irritation they cause.” If necessary, limit venereal inspections to companies where a man has *concealed* disease. I do not recommend routine venereal inspections, but I do strongly advise searching *medical* inspections by companies as advocated by Surgeon-General Gallwey in the Advisory Board Reports in place of the weekly one for the whole Regiment. Numerous men come under notice at large military hospitals with syphilitic and other skin eruptions who have escaped observation at the weekly health inspection, commonly because they are absent from it, or are inspected with shirts on.

Captain Howell, R.A.M.C., makes the following suggestions (Advisory Board, First Report):—

(1) That no official notice be taken of the first venereal admission or of any secondary syphilis, but that for every subsequent admission for venereal disease, a V. to be entered on the man's Regimental defaulter sheet.

(2) That all guards and fatigues missed by a man being in hospital for venereal disease, excepting first admissions and secondary syphilis admissions, should be made up by the man on his discharge from hospital.

(3) That extra drills be imposed to regain the efficiency lost while in hospital. (I think only in those cases where *concealment* has been practised.)

(4) At home permanent passes, and in India shooting passes, not to be granted to men having many entries for venereal disease. (I think only if concealment is frustrated.)

(5) The number of V.'s in a man's defaulter sheet to be taken into consideration by the man's Commanding Officer before promoting him, or assessing his character on discharge.

(Valuable, if concealment is frustrated and medical inspection thorough.)

(6) Any man who has suffered from syphilis not to be granted permission to marry until he has had a full course for syphilis, and has been clear of an entry for syphilis for at least two years.

(7) Any man who has had no admission to hospital for an officially fixed period, say one year, should have his previous V.'s cancelled.

(8) Regiments showing an annual admission rate for venereal disease much in excess of the average admission ratio for the whole Army, should be debarred from proceeding on active service till all regiments showing less than the average rate have proceeded to the front, and even then should, if possible, only be employed on the lines of communication.

“The question of publishing an annual table showing the incidence of venereal disease by regiments might be considered. To be of practical use this would have to appear much earlier than the Annual Returns A.M.D. Lieut.-General Goodenough, when commanding in South Africa, called for monthly returns of venereal admissions by companies; he informed company officers what the average was, so that they could see whether their companies were above or below this figure.

“If any of these proposals are adopted, the fact that anything in the nature of a punishment tends to the concealment of disease must be borne in mind.” It should, however, be practicable to frustrate concealment by properly directed *disciplinary* effort, financial in nature if possible. A code of rules should be drawn up for the guidance of Officers Commanding units or stations. At present in the Army there is too much diversity of opinion on the cut and dried principles underlying both prevention and treatment.

Captain Howell notes “the good results obtained by the R.A. at Aden, by having a special ablution room in the bazaar supplied with antiseptic lotions.”

*Local Applications.*—Giovanni,<sup>1</sup> as the result of a number of experiments, states “that very thorough washing with soap and water immediately after exposure to infection will prevent the formation of a soft chancre, and states that 1 in 1,000 perchloride of mercury, if applied for one minute within eight hours of infection, will have the same effect.” Any oily substance lessens the risks of abrasions, and also tends to prevent the access of the

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<sup>1</sup> First Report Advisory Board. “On Venereal Diseases in the Army.”

syphilitic virus by blocking the minute orifices in the mucous membrane. An ointment of calomel one part, lanoline two parts, is stated by Roux and Metchnikoff to be an absolute preventive of syphilis, if applied to the part within twelve hours of connection.

*In the French Army* the following rules have been adopted:—

- (1) Lectures to the men.
- (2) Monthly examinations of the men in *private*.
- (3) *Secret* register of syphilitics.
- (4) No punishment is awarded unless the disease is *concealed*.
- (5) Houses of diseased prostitutes are put out of bounds.

“The French Colonial Corps suffer severely from venereal disease. In most French Colonies there is no regulation of prostitution, and where it does exist it is very inefficiently carried out.”

*In the United States Army*.—“In Cuba, *weekly* inspections for the detection of venereal disease were held. Those so suffering were treated in hospital, or as out-patients confined to Barracks.”

I think, if medical inspection is thorough and concealment thereby frustrated, the confinement to barracks principle should always be adopted with men concealing disease, or who have treated themselves in barracks. This is possible under Army Order 158 of 1903. I am utterly opposed, however, to the indiscriminate punishment of men suffering from venereal diseases, as such punishment, whether financial or otherwise, tends to defeat the real object in view, to wit, the reduction of inefficiency because the indiscriminate punishment rarely stops men contracting disease, but makes them conceal it, with the result shown in Appendix I.—a prolonged stay in hospital.

At the Second International Congress, Brussels, the only resolution adopted which affects the Army was as follows:—

“That all conscripts joining a regiment be given a short pamphlet describing the dangers of gonorrhœa and syphilis. This is also to contain a note to the effect that the date of an attack of venereal disease must be remembered in order to correctly inform the medical officer of the fact, should it be necessary later on; also a brief reference to the dangers of alcoholic indulgence and of tubercular disease. This pamphlet is to be kept by the man on his discharge from the Army.”

Such a pamphlet, I think, ought to be given to every British soldier, and his receipt taken for it. His Company officer should also see that he keeps it in his possession and reads it.

Prussian law "requires notification in the following cases:—

"(1) If the case is likely to be a source of venereal contagion, *e.g.*, secondary ulcers of the mouth among employees in workshops, or poor people living in overcrowded dwellings.

"(2) Civil doctors must inform the Commanding Officer when treating soldiers for venereal disease."

I think every case of venereal sore, or gonorrhœa, in *civil* life, should be treated in hospital, or segregated—or otherwise penalties attached for the transmission of disease to others as exists in some countries.

"When the Contagious Diseases Acts were repealed, the existing Lock Hospitals were closed. In some of the garrison towns the local authorities appealed to Government for assistance in maintaining lock wards in the local infirmaries, on the grounds that a military garrison attracted prostitutes who, when sick, had to be cared for at the expense of the ratepayers. In certain cases the justice of these claims was admitted, and grants were sanctioned in the following cases: Aldershot £875, Cork £490, Naas £100, Dublin £250, per annum."

There should be more local infirmaries, and women encouraged to use them when diseased.

Prior to invaliding the men to England, prolonged early change to sanatoria in India should be tried, thereby minimising the number of cases of early invaliding. Invalids from abroad who recover after the sea-voyage to England should be drafted back to India from Woolwich or Netley, and men of good character afforded a chance of getting to England (good character to include freedom from venereal disease), or preferably discharged the service unless the man is specially valuable to the State. I believe that stringent disciplinary action of this nature would be effectual as a check against men too commonly exposing themselves to infection and would make them report sick at an early stage when their diseases are more amenable to treatment. At present the man has a good deal to gain and very little to lose by being invalided from abroad. Appeals to the common-sense of the men beget an interest in morality, the object being to promote a healthy tone, which is more marked in some regiments than in others, and to augment the advantages of self-control by placing self-indulgence at such a very obvious disadvantage as can be at once realised by a young soldier at the commencement of his career. At Deolali, at Netley, and at large military hospitals such as Woolwich, London, &c., the effect of various methods of treatment could be more systemati-

cally contrasted, and more uniform results could thus be obtained. A specialist officer could be posted to Deolali, or equivalent depôts. Prior to being sent to England some invalids for venereal disease could be more thoroughly treated on the lines of Aix-la-Chapelle. The conflict of English opinion on treatment in the second report of the Advisory Board is in marked contrast to the unanimity of opinion on the Continent in the third report of the Advisory Board.

A Commission, therefore, should be appointed in England, and in India, to thoroughly study the relative effect and the proper limits of local measures, so as to obtain more general uniformity of preventive measures and more uniform results.

#### PREVENTION BY ADMINISTRATIVE METHODS IN MILITARY HOSPITALS, BARRACKS, AND PRISONS.

This resolves itself into efficient "statistical record" checked by careful administration. Accurate *record* is the bedrock on which to arrive at reliable data, and on which to base any really conclusive opinion as to the relative merits of different forms of treatment in syphilis. To ensure success, the syphilis register, syphilis case sheet and medical history sheets of all men with syphilis could be closely inspected every six months by the Officer Commanding Station Hospital. These documents are frequently not properly written up, or not obtainable. The syphilis case sheet should be signed by the officer taking the notes.

A copy of the printed instructions, "Procedure in Cases of Syphilis," could be pasted in front of every syphilis register, and be more generally studied and rigidly adhered to. For convenience sake, the "Syphilis Case Sheets" and medical history sheets of men in hospital, in small stations, can be kept at the back of it. This simple procedure better ensures the completion of these documents. The register could be kept in charge of the Ward-master, or special clerk in large hospitals. The chief use of the syphilis register is to ensure an accurate *record* of men suffering from constitutional syphilis. A special clerk therefore should be authorised in all large hospitals, in order to make him interested and useful, and he should enjoy the privileges of the clerk's section.

The "Syphilis Case Sheets" should be completed on *admission*, both in the case of primary and secondary syphilis, but the cases not entered in the register until undoubted syphilis is apparent.

The following particulars should be entered on "Syphilis Case Sheet." First, date of connection and situation of chancre; secondly, induration of chancre; thirdly, induration of inguinal glands and whether one, or both, chains of glands were enlarged before the rash appeared; fourthly, the variety of rash, or sore throat; fifthly, the weight before and after the occurrence of rash; lastly, the effect of a particular line of treatment on the lymphatic glands, and whether *hospital* treatment improved the general health. The syphilis case sheet can be improved on (*vide* Appendix XXIII.). Attendance rolls should be well drafted (*vide* Appendix XXIV.).

There should be a weekly and a monthly roll, the latter for men who have had six to nine months' careful treatment, and for those who are undergoing a rest between courses of injections on the "chronic intermittent" plan. This monthly roll enables the Medical Officer to give more detailed inspection and treatment in large military stations to the earlier and more urgent cases on the weekly roll. The men prefer the less frequent attendances, and Commanding Officers are thus more willing to fall in with the hospital requirements. Men are brought from the monthly on to the weekly roll when their course of injection is due, or if external manifestations are apparent.

All soldiers suffering from syphilis, or severe gonorrhœal complications, should be given a certified extract from the medical history sheet, or syphilis case sheet, on leaving the army. This certificate is for personal use when going to a civil hospital. Adverse comment is frequently made by surgeons at such hospitals in cases of severe tertiary, or brain lesions, and discredit may thus be unfairly thrown on the Army, where, as a rule, syphilis is much more thoroughly treated than in civil life, because the men are treated in hospital under control, whereas at civil hospitals they merely receive drug treatment as out-patients.

It is not practicable in dealing with large numbers of venereal patients to impress verbally important minutiae on their minds. Advice leaflets are now given to every soldier diagnosed syphilis on admission to hospital. These should be retained on leaving the Army. They should also be posted in venereal wards. These advice leaflets are given to out-patients at the Lock Hospital, in London, and on the Continent.

It frequently happens that men who report sick with relapses, or with the later constitutional (tertiary) manifestations of syphilis, have never had any entry for the primary, or early secondary manifestations on their medical history sheets. This

arises from several causes. Firstly, the medical history sheet is very commonly not sent from the regiment until applied for (*vide* K.R., paragraph 1710); secondly, the frequent changes of medical officers, or clerks, cause the exact nature of the disease to be overlooked, or inaccurately entered; thirdly, the habit of treating men as out-patients may preclude the necessary entry. For instance, a case of "venereal sore" is discharged hospital when the chancre has healed. Mild secondaries occur, but the case is treated outside by intramuscular injections and the necessary entry may never be made on the medical history sheet, because it has been returned to the regiment on the man's discharge from hospital.

Soft chancres should, I think, be recorded as *non-infecting* chancre. The term "soft chancre" is misleading, since infecting chancres (syphilis) may in some instances not be appreciably indurated, or may not have been seen in the indurated stage. The nature of the initial lesion, such as induration, and the class of chancre should be accurately described on the medical history sheets, as well as the condition of the inguinal glands. Induration in the chancre (excepting pseudo-chancre induré) is pathognomonic of syphilis. In these extremely rare exceptions the normal condition of the lymphatic glands will usually suffice to clear the diagnosis. The nature of secondary manifestations should be invariably specified, and the variety of rash noted, or other distinctive evidence of syphilis, such as sore throat, ulcers in the mouth, condyloma, alopecia, &c.

In cases of syphilis, the *weight* on admission and on discharge from hospital could be recorded on the diet and medical history sheets. This acts as a check on the syphilis case sheet, and affords a ready means of estimating the value of treatment and the degree of individual interest. In order to do this a standing order is given to the Ward-master that every case of syphilis will be weighed stripped, on admission, once a fortnight, and on discharge, and the weight recorded with the date on the margin of the diet sheet, as the weight is to tubercle and syphilis what the thermometer is to fever—our best guide. These weighings should take place, if possible, in the presence of an officer, and no effort be spared to ensure success by a carefully devised system of check and counter-check. The soldier takes great interest in these weighings and consequently in his case. The weight of untreated syphilis cases before rash develops falls; this can be arrived at by record. The weight has a tendency to go on falling unless treated in hospital in the early

secondary stage by diet and the judicious use of mercury. Every case admitted with primary syphilis should remain in hospital two months until the initial secondary rash has come, or until quite fit for out-patient treatment. Every case of severe *relapse* of secondary syphilis and re-admissions should remain in hospital about four weeks, according to the nature of the case, and until all glandular enlargement is well in hand or has subsided, as this forms the best test of treatment. When this is done syphilis in the station is kept in hand, entry in the syphilis register is ensured, the confidence of the patient is gained and, excepting tropical stations, invaliding is very rare and total inefficiency is very considerably reduced. Otherwise out-patient treatment, when practised too early, frequently means the non-recognition of syphilis, vitiated statistics and more inefficiency.

*Paris : Class of Case Treated in Hospital.*—"All cases of recently acquired venereal disease, or those which can be regarded as capable of communicating the disease to others, are admitted to hospital for treatment. The only cases which are treated in the regimental infirmaries, or as out-patients, are cases of latent or of long-standing syphilis, which do not appear to be capable of infecting other men in a barrack-room. In hospital, syphilitic patients have special table necessaries with a distinctive mark, to prevent non-syphilitic patients from accidentally using them."

*The Daily Routine of Hospital Duty in a Venereal Division.*<sup>1</sup>—"The Medical Officer in charge of the *division* makes a morning visit to each ward. The Medical Officer in charge of the *ward* is present with the notes of the case. Each patient is visited in turn, and, if necessary, examined, his condition and progress discussed, and any alterations as to diet or treatment are decided on and noted on his case sheet. When all the wards have been visited the Medical Officers adjourn to the operating room for the division. Long white operating coats are put on, the patients are called in turn, and any treatment necessary, *e.g.*, application of bandages, passing bougies, giving mercurial injections, &c., are carried out by the Medical Officers, assisted by specially trained orderlies."

Until the actual causation of the complications of venereal diseases in the Army is more accurately determined, a special annual report on these diseases could be furnished from large military stations compiled by the officers in charge of the cases

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<sup>1</sup> Third Report Advisory Board. "Treatment of Venereal Diseases in the Army."

of syphilis and their reports published. These reports should embody succinct suggestions for the reduction of venereal disease in each particular Station, and if sound, the suggestions at once given effect to. More detailed attention could be given to venereal diseases in the yearly Sanitary Report of the Commissioner with Government of India and in the Army Medical Reports.

It is suggested that a condensed abstract of a well-thought-out scheme might be made to frustrate concealment by ensuring its absolute detection and punishment in military stations. These condensed abstracts to be confidential in nature, and sent to each officer commanding a Unit, or Station hospital. Under the existing state of things, numerous soldiers frequently evade the sentences of courts martial by reason of venereal disease, and that is one reason why a soldier conceals disease, especially gonorrhœa, since it is a valuable asset for escaping punishment, and he is rarely reported for concealment. If reported, his sentence varies, or he is not punished at all. If he receives a sentence it is not probable that he will get a greater punishment than that which he has evaded, and this counteracts the effect of discipline.

The Commanding Officer of a Unit could be furnished on the sick report with a medical opinion in regard to every case of concealment admitted to hospital. If the man did not actually conceal disease he might also be informed whether he was dilatory in reporting sick. Having got this opinion, endorsed if necessary by the Senior Medical Officer, the Officer Commanding the Unit should act. A Medical Officer in reporting cases of concealment should be guarded in his statement and safeguarded, if necessary, by a second opinion. The quite unnecessary amount of inconvenience to which a Medical Officer may be subjected, owing to attendance at courts martial, should he report a case of concealment, in large measure prevents cases being reported at all, and a court assembled to try the man is apt to undervalue the technical nature of the medical evidence. Three identical cases simultaneously reported received three different punishments, which would appear to show the need for a revision of procedure.

The fact of concealment in aggravated cases could be first investigated by a Medical Board, and a court martial could then act on that opinion. I think, however, that all *ordinary* cases should be dealt with by the Commanding Officer on a definite scale as in cases of drunkenness. It does not do to rely too impli-

citly on the rather thin *ipse dixit* of a soldier suffering from venereal disease who says "he didn't know he had it," or who contracted it at the closet. Especially is this the case when that man has also reported sick, as commonly happens, to evade punishment for military offences or only after sentence of court martial has brought his disease to notice. A soldier is medically examined before trial, but it is possible to deceive a Medical Officer as to the existence of gonorrhœa by first urinating, or squeezing the urethra, or inserting cotton-wool. To avoid difficulty only *obvious* cases of concealment should be dealt with by the Medical Officer. An example here and there is quite sufficient to considerably lessen the amount of concealment in a Unit, and to markedly reduce the prevalence of disease and the more severe cases. The General Officer Commanding can ascertain monthly from the hospital whether any man, or any particular Unit, is concealing disease, and call for reports by Companies. The worst cases of concealment, however, are amongst Non-commissioned Officers who commonly go to civil practitioners. Notes could be given of numerous cases. It is natural that young soldiers should consort with women, and that they should become diseased if the State neither controls prostitution nor isolates diseased women, but restricts marriage. The soldier should not be punished for the mere accident of contracting disease unless he habitually contracts it or conceals it. Unless the State, therefore, ensures that concealment means a greater loss to the individual, the State and not the soldier is eventually the loser through his reduced efficiency. In India alone I think the inefficiency from venereal diseases varies from one-half to a million days yearly in loss of service, at 7d. per diem.

Patients with congenital phimosis occasionally develop severe and rapid œdema of the prepuce. This condition may be associated with a balanitis from the irritation of an unclean connection and without any underlying ulcer, or urethral discharge. Owing to the rapidity of onset, great care should be exercised in such cases in not too readily causing a soldier to be crimined with concealment of disease. Phagedæna also not infrequently attacks ulcers under a congenitally phimosed or inflammatory œdematous prepuce, and a soldier should thus be given the benefit of any reasonable doubt. Circumcision markedly protects against venereal sores. This is conclusively proved by statistics amongst native police in India, and explains the relative immunity of Jews to syphilis, but not to gonorrhœa.

Obvious cases of concealment ordinarily include those men

reporting sick with large Hunterian induration with or without bubo (suppurating or otherwise), or with a rash when the chancre has been concealed and a scar exists, also cases of chancre with associated suppurating bubo, and gonorrhœal patients who only report sick on the occurrence of epididymo-orchitis, or gonorrhœal rheumatism with effusion.

*Absentee Reports.*—Men attending for syphilis as out-patients are through oversight very commonly sent on furlough by their commanding officers, without first consulting the hospital authorities, or being inspected. Men are commonly taken for parades and duties on the days, usually once a week, when they are required for inspection and treatment at the hospital. Syphilitic cases may be selected by Commanding Officers for Indian drafts, or transfers, and may never be seen by the Officer-in-Charge of syphilis out-patients. Men should not, I think, be sent abroad within the first six months from contracting syphilis, since the expense of later invaliding them home has to be considered. These common irregularities are all preventable.

In large military stations, the syphilis cases in barracks attending for treatment should, I think, be always seen at the Station hospital by the same officer, preferably of Field rank, and frequency of change avoided. Frequent changes tend to dislocate any system in vogue and as a matter of practice irregularities at once occur and attendances vary. Junior officers should not, I think, be given the supreme control of venereal wards in large stations, since many questions arise which necessitate a longer acquaintance with service requirements.

An officer could possibly be detailed direct from the War Office to pay surprise visits to stations and enquire into the question of the concealment of disease, when the ratios of venereal disease are excessive, and every soldier be present, and steps be taken to deal with the common practice of soldiers reporting sick the day they know a venereal inspection is to be held, in order to avoid being reported.

A representative committee consisting of the General Officer Commanding, or his deputy, the principal Medical Officer, or his deputy, and the Officer Commanding the Unit, could meet monthly at each large military station to discuss the military aspects and practical methods of prevention in that station. No universal scheme can ever be made sufficiently elastic, or all-embracing, to meet the requirements of each individual place.

Venereal diseases are very imperfectly studied in England, as contrasted with France and America. In London civil hospitals

there are not any special appointments on the staff for venereal diseases as apart from skin diseases, as there are in America; and only fifty-seven beds for in-patients. At Netley, Woolwich and London, venereal diseases ought to be more specially taught and candidates examined for their commissions, or promotion, since the inefficiency resulting from these diseases is a long way greater than that from any other class of disease in military medicine.

In some military hospitals there are ward annexes. At one large station there is a separate operating room specially equipped. The latter should be universal at large stations, as on the Continent.

*Specialists.*—"Two junior Stabsaertze are always detailed to study skin and venereal diseases in the University Klinik of Berlin. After a minimum period of two years' work there, they may be appointed to the charge of one of these divisions, or may remain for a longer period as assistants to the professor. In other universities similar appointments for study are made."<sup>1</sup> This is roughly the routine at large stations such as Woolwich, London, Malta, Egypt.

There are at present very few Officers R.A.M.C. who have taken the special certificate in venereal diseases and dermatology. Such officers, as opportunities occur, are now posted as specialists at large military centres.

As suggested by Surgeon-General Evatt, "Encouragement should be given to Medical Officers to study venereal diseases, by the establishment of a Professorship." A premium on efficiency must necessarily increase interest, reduce the expense of establishments, and ultimately repay the outlay. Selected Medical Officers could be more frequently afforded the opportunity of studying the preventive treatment of venereal diseases amongst foreign armies and in foreign hospitals; and study leave granted for London hospitals.

I have merely endeavoured to suggest the general principles and broad lines on which the various forms of prevention may be best conceived and best maintained. Time will suggest other means; the criticism of existing measures will supply fresh methods; and interest combined with energy will achieve success.

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<sup>1</sup> First Report Advisory Board. "On Venereal Diseases in the Army."

### III.—TREATMENT.

Patients recently discharged from hospital and relieved from military duties in barracks should be more amenable to treatment; but in some instances, the idleness gives rise to more drinking, more smoking, and more syphilis. The two former contingencies it is highly important to guard against with a view of preventing the relapse of syphilitic manifestations. I find, therefore, as a means of reducing inefficiency that it is ordinarily better to make the man when an out-patient do his full duty, or otherwise to re-admit him to hospital.

Excluding unusually severe, malignant, cachectic, or debilitated cases, as indicated by anæmia and considerable loss of weight, a soldier in properly treated cases, after a period of six months is ordinarily fit for foreign or active service. A history of associated malaria, alcohol, scurvy, tuberculosis, or severe anæmia, however, should justify a rejection for active service until the above conditions have been remedied. Further, in these contingencies, a man should, as a rule, be in hospital, as it is ultimately more beneficial for his health, is better in the interest of the service, and reduces the chances of later invaliding.

Severe papular or pustular eruptions, with or without iritis, or albuminuria, ordinarily indicate severe infection with syphilis, and it is necessary to be much more stringent in dealing with such men than with the general run of cases who have an ephemeral roseolar rash, or mild sore throat, or mild glandular enlargements.

A soldier when under the full influence of mercury as an out-patient is unfit for sentry duty in wet or severe weather, in the first four months from the date of contracting syphilis. Further, alcohol and syphilis, with exposure as an exciting cause, are very liable to induce pneumonia, and I have known cases of death to occur under such circumstances. These considerations suggest the advisability of thorough treatment in hospital, in the early stages of disease as a means of reducing total inefficiency.

A campaign in a good climate like South Africa, or in the Punjab in India in winter, would be beneficial in the quiescent stages of syphilis after the first six months, but in hot parts of India, or in a bad climate, probably the reverse. All convalescing venereal cases sent on active service should, I think, be employed at the base, or on the lines of communication. This procedure, it is believed, would ensure more practical interest in this subject within the regiment, or unit.

Mr. Jonathan Hutchinson states: "If the patient has never had syphilis before, whatever are the characters of any primary sore which he may exhibit, the chances are two to one that the sequel will prove that it contained the germs of true syphilis."<sup>1</sup> I do not acquiesce in this statement, and the proof is not given. I consider that it is about three to one against (*vide* Appendix I.), and military statistics, in India, bear out this opinion.

In the Army, where all cases of venereal sores are treated in hospitals, and under continued observation, exact diagnosis is more possible than in civil life where they are treated as out-patients, and it is found on experience that even under such favourable circumstances the syphilitic nature of some chancres in the form of abrasions, can only with certainty be demonstrated when the rash is seen.

Before making a definite diagnosis of syphilis on the apparently indurated nature of the chancre, the researches of Fournier in France, on pseudo-chancres indurés, should be considered, more especially in any case of apparently indurated chancre, where the nearest lymphatic glands are not simultaneously enlarged, amygdaloid, or bullety, since pseudo-chancres indurés may, it is said, closely resemble the true Hunterian chancre. In a patient previously the subject of syphilis, local re-infection may give rise to an indurated chancre, and although cases are quoted as occurring, I have never seen a rash appear or a true second attack. Further, syphilitic chancres and rashes may relapse, and in rare instances gummatous ulcers of the penis occur. I recently had a case of gumma of the penis in which the inguinal glands were normal, and there were large tertiary ulcers elsewhere. The case was an invalid from abroad where the diagnosis was made, of primary syphilis with phagedæna. The patient, who only weighed 6 stone, had constitutional syphilis three years previously, and the necrosis occurring in the gumma on the penis naturally simulated a phagedænic condition.

Whilst not discrediting the value of the time since infection and local characteristics, it is well to recognise the fact that because a chancre is *indolent*, this is not necessarily a justification for assuming it is specific (syphilitic), since non-infecting chancres are often slow healing, and in syphilis the incidence of appearance after connection is frequently a very doubtful criterion on which to base a definite diagnosis, as truthful

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<sup>1</sup> "Syphilis." Hutchinson.

histories are hard to elicit. The time limits were worked out many years ago, on experimental, or vaccinal inoculations, from ten to forty days, with an average of twenty-five days. Further, syphilis commonly ensues after *mixed* chancres, that is to say, a double infection chancre (due to the bacillus of Docré and the *Spirochæte pallida* plus staphylococci) which rapidly develops and possesses the ordinary characteristics of non-infecting (soft) chancre in the early stages, and induration is perhaps later developed and is commonly not observed, more especially in frenal ulcers, in balanitic ulcerations, and in abrasions followed by syphilis. The virus of syphilis is very rarely inoculated in a pure state, hence initial ulceration locally on the penis, whereas in vaccinal syphilis a papule occurs in the skin at the point of inoculation. The ulcer on the penis develops and becomes indurated, and later ulcerates, which gives rise to the error that a papule is first seen. The friction of the prepuce, irritation, and the moist situation rapidly tend to ulceration on the penis, although, in rare instances, I have seen a papule on the glans penis which disappeared without ulceration at any period and syphilis followed.

Constitutional syphilis may, in rare instances, follow apparently benign non-indurated sores, or suspicious sores. A chancre in the soft substance of the glans, as distinct from the more tense corona glandis, may not be indurated owing to its situation in softer tissue. Scabbing ulcers on the dorsum, or on the external surface of penis may also not be indurated, or much ulcerated if protected from irritation, although an indurated cicatrix may in some instances be later evident. Parchment (*i.e.*, superficial) induration is obvious in other cases.

Although syphilitic chancres are, in the large majority of instances, single, the *non-infecting* variety of chancres also frequently appear single, more especially in cases properly treated in hospital, where auto-inoculation has been prevented by anti-septic treatment. Amongst patients presenting multiple sores, balanitic excoriations, or abrasions, one of these may later prove to be syphilitic, or a ring of induration may develop from the whole excoriated surface.

A *non-suppurating* infiltrated matting of glands in the groin in association with a chancre should always cause the possible syphilitic nature of the disease to be entertained, but mixed chancres containing the virus of syphilis may give rise to suppurating buboes, so that suppurating bubo *per se* is by no means necessarily pathognomonic of non-infecting chancre (soft chancre)

as is commonly taught. Urethral chancres occur near the meatus, or within the urethra, and there may also be a urethral discharge closely simulating gonorrhœa. The two diseases, gonorrhœa and syphilis, are not infrequently simultaneously observable in the same person, and as the gonorrhœa ceases an indurated chancre may develop. I had a case where a man was treated in hospital for gonorrhœa and orchitis, and six weeks later an erratic chancre occurred in the left calf, with typical inguinal glands, and later a secondary rash. Erratic chancres may occur in all sorts of unexpected places. I have seen four cases on the tonsil, and one in the centre of the forehead. The lip and eyelid may be infected, and in certain countries the anus. It is as well to remember this latter contingency before classifying the case as syphilis d'emblée (*i e.*, syphilis occurring without an initial local lesion).

There are three classes of soldiers with *syphilitic* chancres. First those who report sick early. The induration in these cases may develop as the chancre slowly heals in three to four weeks, and is usually preceded by induration in the proximal lymphatic glands. Secondly, those men who have concealed their disease in barracks in the early stage, and are admitted with fully developed large Hunterian indurated chancres in which the ulcer is nearly or quite healed, the inguinal glands unilaterally or symmetrically enlarged, and often with the syphilitic rash on them. Thirdly, cases of concealment admitted with acute inflammatory phimosis, the result of balanitis plus chancre, or with a large bubo.

Any case presenting induration in the chancre is unfit for out-patient treatment in barracks, as such chancres commonly break down and ulcerate when the initial rash, or other active manifestations appear, and so disease is spread amongst women, and other men in the garrison become infected. Cases of venereal sore without induration in the chancre, or in the nearest lymphatic glands, and associated with a *suppurating* bubo, usually prove to be *non-infecting*, and can ordinarily be discharged when the chancre and bubo have healed, to attend weekly for inspection for rash, &c., for a period of at least *three months and a half* from the date of first appearance of the sore (*vide* Appendix I.).

The only possible objection that can be raised to the cauterisation of chancres is, that the character of the sore may, in rare instances, be disguised. The proportion, however, of *non-infecting* to *infecting* chancres is, I believe, about three to one (*vide*

Appendix I.), and buboes occur in probably 40 per cent. of non-infecting sores, if men delay in reporting sick with chancres, or are employed on hospital fatigues with an acutely inflamed ulcer on the penis in the first few days in hospital. Cauterisation rapidly converts an unhealthy sore into a healing ulcer, stops phagedæna, tends to limit bubo formation, and considerably reduces the time spent in hospital. The application of a caustic does not in reality alter the nature of an *infecting* sore, and careful observation will very soon elicit the difference between mere inflammatory thickening that may only in some rare cases arise as the result of injudicious application, and the induration, often cartilaginous in nature, of an infecting sore. The condition of the glands in the groin, which is the first guide in early syphilis, nearly always comes to our rescue in the case of *infecting* sores, since they are almost invariably discretely enlarged and indurated, and in syphilis a rash occurs later whether the chancre is touched or not. If we are doubtful, it is not necessary to apply the caustic carbolic acid. In rare cases, such as farriers, who apply blue stone to an ulcer on the penis, a condition of pseudo-chancres indurés may occur as the result of irritation of a sore which may not be syphilitic. Non-infecting sores (soft chancres), if unhealthy looking and discharging, should be locally touched with pure carbolic acid, which is painless, on admission, and every third morning, according to the indication of the particular case. Chancres, unless phagedænic, should not be touched if obviously indurated, or undoubtedly syphilitic, or if they bleed profusely before touching, or after touching, since such bleeding, as in simple inflammation, is a sign of commencing resolution. An excellent dressing later consists of a powder of pure iodoform together with a piece of lint soaked in black wash, and frequently changed. Balanitic sores, or abrasions, often heal better with a solution of grs. ii. to the ounce silver nitrate on lint. If there is a tendency to inflammatory phimosis in addition to the chancre, the patient should soak in a hot bath four times daily, or even day and night, and on getting out, the prepuce should be stretched with forceps, and carbolic oil lint with iodoform should be packed under the foreskin. This will often obviate the necessity for later incision, or circumcision. In extreme cases of phimosis, however, operation is necessary. The procedure recommended by Taylor (America) is "to incise the foreskin bilaterally," and apply pure carbolic acid to the sores. These are commonly phagedænic under a phimosed foreskin. A median dorsal incision, however, is usually as good, if care is taken not

to cut through the chancre. Primary circumcision, except in phimosis associated with gonorrhœa, is, I think, bad practice, as the wound commonly becomes infected, and the duration in hospital is often prolonged to three months. It is best to incise, and let the wound heal. When the wound has healed and the thickening subsides a secondary circumcision should be done. If operation is necessary in phimosis complicating gonorrhœa, it should be performed within three days of admission to hospital. If not promptly done, epididymo-orchitis and an unnecessarily prolonged stay in hospital may ensue. It is quite unnecessary to wait until the gonorrhœa is cured before operating. Suppurating buboes should be incised at an early date, otherwise they are apt to burrow extensively, especially in cachectic subjects in hot climates, and so necessitate invaliding. Warmth and rest may sometimes obviate operation, if applied early enough before pus forms. In the case of non-suppurating bubo due to syphilis excision of the glands is not as a rule necessary, since the bubo will commonly subside on local treatment by mercurial inunction, and potassium iodide by the mouth in 10-grain doses. As the mass subsides the individual glands can then be easily made out to be amygdaloid or bullety in shape, and discretely enlarged. The matting in a bubo is due to a periadenitis by lymphatic extension from the perivascular connective tissue in association with the indurated chancre. Iodine, and massage, or electricity locally, are also reported to yield good results in some instances.

Buboes are nearly always due to one of two causes. First, delay in reporting sick (concealment), or treatment by chemists, or others outside hospital. Secondly, whilst in hospital, walking about when marked "bed," the chancre rubbing against the clothes and the irritation thus induced by the exercise, causing the nearest lymphatic glands to inflame and suppurate, and in the case of syphilis, to form usually a non-suppurating matting in the groin, but in other instances a superficially suppurating indurated mass (*vide* Appendix I.). The average duration in hospital of a case of non-infecting sore (soft chancre) is, when properly treated, about two to three weeks, in my experience, and commonly much less with care. If, however, a bubo in the groin occurs, which suppurates and requires incision, the duration in hospital is two to three months (*vide* Appendix I.). As the causation is commonly *neglect* by the patient or attendants, it is obvious that to reduce the period in hospital, and so limit the consequent great loss of service, strict attention should be directed to the foregoing minutiae, and

hospital fatigues be reserved for *convalescing* venereal cases. At present, the too common practice of ward-masters, orderlies, &c., is to employ venereal cases on fatigues quite independently of the above considerations. The treatment, therefore, should be clearly written in the ward prescription book, and in large hospitals, a few practical orders of general application posted on a notice board in the ward for gonorrhœa, venereal sores, and syphilis cases, in order to minimise the occurrence of buboes as much as possible. In the case of a man admitted to hospital with a venereal sore, he should be marked "bed" for at least seven to ten days, as the smallest balanitic ulcers may cause buboes, but hot compresses every half-hour on the day of admission usually convert the average sore into a healing ulcer, and a bubo may be thus prevented. Many writers have advised the withholding of mercury in cases of phagedæna. A lowering treatment has no doubt an ill effect if the chancre is not syphilitic in origin, as is commonly the case in phagedænic ulcers. Local treatment, free exposure, prolonged baths, diet, and stimulants, ordinarily suffice for phagedænic ulcers, except when the nearest glands are typical of syphilis, when mercurial inunctions should be used. The two common causes of this condition are congenital phimosis and neglect by the patient. Sloughing of the soft tissues occurs as the result of the highly infective pus being pent up, and possibly to anærobic growth of some organism. Phagedæna occurs both in *non-infecting* and also in *infecting* chancre (syphilis). Mr. Hutchinson states that it occurs only in syphilis. Most of the extensive cases seen by me occurred in non-infecting chancres, but in a very large series of cases the relative incidence is probably more equal (*vide* Appendix I.).

The grave effects of syphilis are largely due to the original intensity of infection, personal susceptibility to the action of the virus, neglect of early treatment, and intemperate habits. Mercury is by no means an adequate remedy in all such cases. The primary and early secondary stage run a definite course, and no line of treatment can absolutely prevent the evolution of manifestations; but good treatment in hospital in the early stages markedly ameliorates the general blood condition, and better guards against later relapse and tertiary manifestations.

Kaposi says that "treatment in the primary stage disorders the evolution of the symptoms of infection, and makes tertiaries more frequent." In my experience, it is only when treatment is not given because the syphilis is not recognised, when mercury

is injudiciously administered, or when remedies are too early suspended, that tertiaries become frequent.

In the case of a venereal sore, which does not present the classical features of syphilis, mercury should not be given at once. Administration should, I think, be deferred until at least two of the accepted signs of syphilis are present, namely, evident *induration* of the chancre, which is present at some time in probably 90 per cent. of infecting chancres, and indurated enlargement of the proximal lymphatic glands, which is perhaps the most valuable index to early syphilis before the rash appears, and is often evident before induration has occurred in the chancre, or in its cicatrix (*vide* Appendix I.). In those rare instances, however, where induration of the chancre, or inguinal glands, is not apparent, it is better to wait for the further symptoms of constitutional syphilis to appear, such as rash, sore throat, or alopecia, which occur early. It is frequently stated that mercurial administration in the primary stage delays the time of evolution of secondary syphilitic manifestations. I do not consider that this is appreciably so, although the local evidence of induration in the chancre or glands in the primary stage are rapidly dissipated; but I do think that the ensuing disease is considerably modified, and that the general health suffers less in average cases when mercury is judiciously employed in the primary stage. The patient prefers an absolute opinion as to his disease, and if syphilis is definitely diagnosed, will more readily undergo the prolonged treatment which is essential to cure. I always treat clear cases of *infecting* chancre with mercury before the rash appears.

If the patient conceals his chancre and history, and only presents himself with a certain type of macular (rubeolar, roseolar) syphilide, it is difficult in some instances to eliminate measles, since each may have fever, and some syphilides are evanescent. Syphilitic patients with large papular or pustular rashes are also not infrequently sent to small-pox hospitals. The diagnosis of lichen planus, pityriasis rosea, seborrhœic eczema, and other conditions from syphilides is not always easy. It is, therefore, necessary to be guarded, if a clear history of initial chancre, or of lymphatic enlargement is not available or evident. Scars on the penis are very dangerous criteria on which to diagnose syphilis. The largest scars are often due to non-infecting chancre with phagedæna (*i.e.*, loss of substance). Scars on the penis, without any other collateral evidence, are not infrequently accepted as proof positive of syphilis by writers on

nervous diseases, but statistics compiled on such slender data are quite unworthy of credence.

All cases of venereal sore, therefore, in which there is induration, or ulcers of any nature on the penis, in which one or both chains of inguinal glands are typically shotty and discretely enlarged, bullet-like, or amygdaloid in shape, or cases of erratic chancre (that is, not occurring on the glans penis, or prepuce), should, I think, during the chancre stage, be kept in hospital for observation and treated by mercurial inunction. The detection of the early constitutional manifestations of syphilis can then be absolutely ensured. These are frequently very mild, namely, rash, which in my opinion is always present in some degree in cases of syphilis, within four months from infection, and of sore throat, which may in rare instances be absent or *patchy alopecia* which is commonly present, and occurs about the hundredth day from infection, as in alopecia after fevers, and is no doubt due to defective nutrition, like onychia, but tends to resolve naturally even apart from treatment. I disagree with Mr. Hutchinson's view that the skin commonly escapes in syphilis. I have extensively investigated this point, and owing to its great importance state the result of observations extending over a period of fifteen years amongst in-patients in military hospitals where every case is recorded.

The early *non-infiltrated* roseolar erythematous rash, also called rubeolar syphilide (*i.e.*, like measles), which is very common in syphilis, may come and go in four days to a week, is rarely detected by the patient, and is commonly overlooked by medical men. The initial rash and mucous patches in the mouth indicate the natural evolution of disease and the period of most intense activity when the blood is most infective. After the first six to nine months manifestations as a general rule are rare both in treated and untreated syphilis.

Mr. Hutchinson states:<sup>1</sup> "I never expect to see secondary symptoms now if I have seen the case before we begin." This appears to be an unusual experience which is by no means generally endorsed by the opinion of the medical profession. In an experience of over a thousand cases which were thoroughly treated in hospital in the chancre stage by mercury and diet, and in which every resource at present known to the profession was used, *secondary* symptoms (*i.e.*, rash) regularly occurred, and sore throat, or mucous patches in the mouth, were almost invariably

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<sup>1</sup> Second Report Advisory Board. "On Venereal Diseases in the Army."

present in some degree, for a few days, or for a longer period, and the evolution of these symptoms could not with absolute certainty be controlled by any form of treatment, although later relapses could be usually minimised.

INSTRUCTIONS FOR CASES OF "SYPHILIS AND VENEREAL SORE"  
IN HOSPITAL.

(1) Patients with syphilis undergoing treatment in hospital by mercurial inunction will first have a hot bath daily in the bath set apart for them, in order to prepare the skin. The groins and arm-pits will be *closely shaved*, to prevent mercurial pustulation. As much ointment<sup>1</sup> as would cover a shilling will be thoroughly rubbed for half an hour into one groin and inner side of thigh one day; into the other groin on second day; into one arm-pit third day; into the other arm-pit fourth day; and so on for six weeks. These situations are selected owing to the greater frequency of gland orifices, and so better absorption. A piece of lint and a bandage will be applied. The ointment must not be washed off until next morning. Any tenderness of gums, diarrhoea, headache, fever, or new symptoms should be reported to the Medical Officer. The inunction will take place in the presence of the ward orderly, and under the supervision of an officer, and will be omitted every Sunday as a safeguard against mercurialisation. Forty inunctions usually form a course.

(2) A stock gargle (such as acetate of alum or chlorate of potassium), kept in the ward, will be used by syphilitic cases every three hours if there are ulcers in the mouth or throat; otherwise, three times daily after food. The gargle should be kept in the mouth for five minutes. The teeth cleansed twice daily with a soft tooth-brush and the gargle. Cases with ulcers in the mouth will attend after the visit for special local treatment by the Medical Officer. Cases with bad teeth must see the dentist before commencing mercury.

(3) Requisitions for tobacco will not be signed for syphilitic cases in the early stages, as tobacco causes ulcers to form in the mouth, or to become worse, and delays cure.

(4) The ward-master in the syphilis ward will read over these instructions to patients on admission, and will check the treatment book daily, and report any irregularity on the part of orderlies or patients. Patients are weighed stripped on admission, fortnightly, and on discharge.

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<sup>1</sup> Ung. hydrarg. 1 drachm, lanoline 1 drachm.

(5) Cases of venereal sore will, unless directed to the contrary, always keep their dressings on at the morning visits. Iodoform, lint and lotio nigra can be obtained from the Royal Army Medical Corps orderly at 10 a.m., 2 p.m. and 6 p.m., or oftener if ordered. These patients will attend for local treatment and see the Medical Officer after the morning visit until excused. The sore will be washed before attending. The cases are seen in the venereal operating theatre or in the special treatment room.

(6) Walking about with a chancre causes a bubo to form. Cases of venereal sore marked "bed" are only allowed up for necessary purposes such as latrine, ablutions and tidying their bed. Patients marked "bed" will not be taken for any hospital duty. Bubo cases will be dressed twice daily unless directed to the contrary. A pad of wool and a bandage will be applied over the dressing.

Unless some such code of rules is in force in the wards of large military hospitals, the treatment of the case may be neglected by patients or orderlies, and a very great amount of inefficiency ensues. The men read these rules and usually see that they receive their treatment. The results obtained in India, Cairo, Woolwich, &c., have been most valuable. Minute details and system are highly important in large garrisons where there are often a thousand or so admissions to hospital in a year with venereal disease, not counting out-patients.

My usual practice, in average cases, is to give in hospital in the chancre and early rash stage, a five to six weeks' course of inunction of ung. hydrarg. 1 drachm, lanoline, 1 drachm, daily in conjunction with previous hot bath, as soon as a firm diagnosis of syphilis is made. The patient, if clear of symptoms, is then ordinarily discharged hospital. To out-patients I would later for a month prefer to give potass. iodid. 10 grains three times daily, or quinine in liquid form, but for purely service reasons the man usually receives the intramuscular injection treatment. If he is not losing weight or colour he continues his injections or other treatment by courses, *with intermissions*, for another year. If he is losing weight or colour the treatment is suspended, altered, or tonics substituted. If he shows external manifestations, such as mucous patches or sore throat, he is locally treated by first applying chromic acid gr. xv. to 1 oz. and then argent. nit. grs. x. to 1 oz., which forms chromate of silver; or the acid nitrate of mercury, which is often better. If the lesions in the mouth are severe, and do not react to a

few daily local applications, the case should be re-admitted to hospital and dieted, but in mild cases the ulcers readily heal up in a few days and are soon rendered innocuous by the application of the pure acid nitrate of mercury.

In phagedænic destructive ulcers of the throat, local calomel inhalation through the mouth is useful; also carefully touching the ulcers with acid nitrate of mercury, or chromic acid gr. xx.-xxx. every other day, gargling with lotio nigra, or liq. hydrarg. perchlor. 1 in 2,000, and swabbing the throat with equal parts of sulphurous acid and glycerine are all beneficial. Quinine in liquid form is valuable, but mercury should be used with caution. Iodide of potassium with spirit ammon. aromat. and water, should be administered internally in such cases, if the patient can take it. In phagedænic ulcerations of the nose which extend to the cheek, the application to the spreading edge of pure carbolic acid under an anæsthetic, or acid nitrate of mercury, is essential to arrest the extension of disease, in conjunction with very careful dietary, port wine, opium, and frequent washing.

I would prefer as regards its effect on the syphilis, a second inunction course of five weeks when possible, and, if it could be managed, four courses of inunctions as on the Continent, within the first eighteen months, but the first course is much the most important, and two courses will ordinarily break the back of the disease. Inunctions should be thoroughly done with a glass block, and, if practicable, by trained masseurs. Severe cases, however, with eye, ear, throat, malignant, or gummatous complications, and cases of severe relapse, are best treated in hospital, as also is every case in the first two months from infection during the chancre stage, and any that present large papular and pustular eruptions. Under such treatment, if early and promptly carried out, I have not observed lunacy or hemiplegia follow, but have seen the incipient evidences of these formidable conditions frustrated.

Surgeon-General Gallwey states "that he carried out the inunction treatment in the Egyptian army with marvellously good results; but objects to the fact that inunction cannot be carried out for six to eight months like the injection method."<sup>1</sup> The value of all mercurial treatment, however, and of the inunction method in particular, consists of definite *courses*—with intermissions, as during the period of rest, the mercury is gradually eliminated and poisoning is thus prevented. This is

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<sup>1</sup> Advisory Board Report. "On Venereal Diseases in the Army."

the almost universal opinion on the Continent where syphilis is more deeply studied, and a common one in England.

If oral administration in small stations is given to out-patients, the soldier should attend hospital twice daily and receive it from a Non-commissioned Officer, Royal Army Medical Corps. This form, except when men are in hospital, is difficult to carry out, and as a rule should be reserved to guard against relapse, as on the Continent.

It is in the late secondary and tertiary stage, *par excellence*, that administration by the mouth acts well, as the digestion is better than in the initial acute congestive stage, and the combination of iodide of potassium with liq. hydrarg. perchlor. at this period is most valuable. The biniodide of mercury is also good.

The two forms of injection that I have seen most used in the Army are the insoluble grey-oil, commonly known as Lambkin's cream, and the soluble perchloride of mercury in ammonia solution. The grey-oil was introduced into medical practice about thirty years ago by Lang, of Vienna, and discarded. Lafay, in Paris, modified it. Its use is now ordinarily discredited on the Continent, but it is still very largely employed in the British Army.

For injection purposes Dr. Radcliffe Crocker and Sir Alfred Cooper favour the sozoiodolate, and Dr. A. Whitfield the succinimide of mercury, which are *soluble* salts. The latter "considers the use of *insoluble* preparations such as grey-oil as hardly justifiable in view of the recorded deaths from this method of treatment." These deaths are due, I think, to a too continuous administration instead of intermittent treatment. It is common knowledge that mercury, like arsenic, has a cumulative action in the body, so that it is not so much the intake but the output that we must look to. It is, consequently, natural to suppose that *insoluble* salts of mercury placed in muscular tissue may not be *regularly* absorbed, but be suddenly eliminated when we arrive at a maximum lethal dose—as muscles are not primarily intended for absorption. I consider that the curative effect of grey-oil on the syphilis is not nearly as marked as with other forms of the drug, and that the soluble injection method should be reserved for out-patients as a service convenience.

Mr. Charles Gibbs, London Lock Hospital, states<sup>1</sup> that "severe relapses are twice as frequent after injections as after inunction, or pill treatment, and iritis is peculiarly common in the relapses

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<sup>1</sup> Advisory Board Report. "On Venereal Diseases in the Army."

from intramuscular injection." Many of the so-called relapses, however, are cases of secondary ulcers in the mouth aggravated by mercurial stomatitis (*i.e.*, poisoning), commencing behind the last molar tooth. No form of treatment can absolutely prevent ulcers in the mouth occurring in the initial secondary stage of syphilis, and local treatment is absolutely essential to good results; but average cases of undoubted syphilis, when treated by inunctions in hospital in the early stage of chancre and initial rash, do not tend to relapse so much, owing to better regulated absorption and elimination, and in my experience, both in India and in England, iritis is much less frequent.

Objections by soldiers to particular forms of treatment, such as injection, are often made when changes of medical officers occur, or with some personal object in view.

If administration of mercury is made by the mouth, in the *quiescent* stages (*i.e.*, after the first four to six months on an average), the dose should not be more than half a drachm of the liquor. hydrarg. perch., B.P., or 2 grains daily of hydrarg.  $\bar{c}$  creta; if by the muscles, 1 grain mercury in the mercurial cream (at present supplied in bulk to Army dispensaries). I prefer six weekly injections, followed by a rest for one to two months, then a second course of six weekly injections again followed by a rest, and so on. Careful sterilisation of the instruments and skin is essential. After three such courses, the patient is put on a monthly roll, and later brought on to a weekly one for his injections after a period of rest, or according to the nature of the case. This is the "chronic intermittent" plan of treatment (*vide* Appendix XXIV.).

Opium is a valuable ally with mercury at all times, as it checks diarrhoea and promotes diaphoresis. The late Mr. Cutler, of St. George's Hospital, used to say that mercury cured by the diarrhoea it caused. It can be observed, however, that even in normal persons the inguinal lymphatic glands become smaller and more resilient even after one smart mercurial purge. Calomel vapour baths are best suited to severe *external* lesions, such as markedly papular or pustular rashes, and ulcerating gummata, which may resist other methods. Ulcers on the legs should be dressed with equal parts of ung. hydrarg. and lanoline, or with ung. hydrarg. oxid. flav., which is a less septic preparation. Local remedies are essential in all tertiary manifestations. Calomel vapour baths should not be too long continued, or too frequent, as mercurialisation may be rapidly induced, owing to the large extent of skin surface from which

absorption is taking place. I employ Lee's vapour bath in all severe cases, either with or without calomel, according to the necessities of the individual case, and I usually give a course of six to ten baths administered every other day with half a drachm of calomel for each bath.

If mercury be given until the gums are touched, mercurial poisoning may easily occur. Although recommended in some text-books, such a procedure is opposed to all reason, but stomatitis can be largely guarded against by daily painting the gums with an astringent solution, by gargles, by the daily use of hot baths, and by periods of rest from mercury.

I object to any method of pushing mercury and making the patient fit in with the treatment. I have seen men broken down by mercury as well as by syphilis. A mercurial enteritis from poisoning by the drug may simulate dysentery, and even cause the man to be invalided for the latter complaint.

I have seen a case of mercurial diarrhoea with syphilitic roseola and syphilitic fever treated in the enteric ward. One or two generations ago, patients, as a result of mercurial stomatitis, not infrequently brought their teeth in their hands to show the surgeon. This occurred both in civil and military practice, and the abuse of a valuable drug led to the disuse of it, or to the neglect of all treatment. The severe results were lamented in the Peninsular War as fully evidenced in a former article.<sup>1</sup>

It is the practice to give mercury more vigorously in the first than in the second year. If the person is robust and the attack severe, as evidenced by an infiltrated large papular, or pustular rash, a larger quantity of mercury in the early stages is often well tolerated by a patient in hospital. If, on the other hand, the infection is a mild one, as evidenced by a non-infiltrated roseolar rash, or the patient is nervous, or debilitated from any cause, or has carious teeth, a much smaller dose may be badly borne. No hard-and-fast rule as to dosage therefore can ever be laid down, which would suit every case, but the merits of each must be absolutely decided by the experience of the individual practitioner.

The duration of administration is, in some measure, dependent on the type of constitutional disease, on idiosyncrasy, and on the general health of the patient. As a rule, however, mercury should be efficiently, invariably, but intermittently given, for twelve months, although the first six are much the

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<sup>1</sup> "Malignant Syphilis," *Journal of the Royal Army Medical Corps*, 1905.

most important, with gradually increasing longer intervals for the second year, and combined with mixed treatment, with potass. iodid., or tonics, during the intermissions, according to the general condition.

Owing to our ignorance of the laws of assimilation and elimination, I do not give the patient in any stage as much mercury as he can stand, because that, though advocated by some persons, constitutes an abuse of the drug, as it commonly results in poisoning and mercurial stomatitis from at first being unduly accumulated, and later too suddenly eliminated, and this would adversely affect the general health, which is a most important consideration, as the manifestations of syphilis are commonly in inverse ratio to it. Treatment is directed towards enabling the patient to take the drug by regulating elimination and inducing metabolism by taking baths, by good food, and by gentle exercise in the fresh air. If the bactericidal properties manufactured in the blood are to effect the cure of syphilis this must necessarily result from increased metabolism due to the very careful administration of mercurial preparations. Such metabolism is primarily evident in the *lymphatic* glands which become reduced in size and secondarily in the other tissues. It is a remarkable fact that even in the absence of treatment the lymphatic glands do not remain permanently enlarged, which shows the active part played by Nature apart from our remedy. In a case of syphilitic testicle, on the other hand, the organ may remain permanently enlarged and hard.

The continuance of large doses, in any form, creates a markedly retrograde effect by causing anæmia, loss of weight and general condition, as well as by acting as a systemic poison, and probably prevents anti-bodies forming in the blood. The factor, general condition, when adequately maintained, has as powerful an effect as the mercury in improving the status of the red blood corpuscles and in eliminating the syphilis by improving the tone of the eliminatory organs. Anything, therefore, that improves the condition of the blood and increases elimination through the liver, kidneys and skin, is a valuable complement to the mercurial course and a necessity after it. The absence of cachexia of the face is a valuable index to the progress of the case and should guide us in interrupting, or continuing, the mercurial course. Patients seem to do better in the summer months, in England, presumably on account of increased diaphoresis, and syphilitic cases do much better if pus is freely washed off ulcers, a point that is no doubt recognised, but commonly not sufficiently attended to.

“If blood counts be made, it will be found that the count of *red* cells, and the amount of hæmoglobin, increase during the first three weeks of mercurial treatment begun when secondary manifestations of syphilis have first occurred. After that time, if mercury is still given, the hæmoglobin, and later the number of red corpuscles begin to decline.”—(Cabot).

The blood, therefore, should be examined in the primary and early secondary stages of syphilis, as in malaria or other diseases. Dr. Arthur Whitfield, who performed Justus' blood test in twenty-five cases, considers “the test of great value though not infallible.”<sup>1</sup>

The weight is a crucial point, and is probably proportionate to the severity of attack, to the condition of the blood and to the satisfactory nature of our remedies, since great variations are often apparent in the weight of untreated and properly treated syphilis. In severe cases treated, or otherwise, the weight falls steadily for a time, and anæmia is more or less marked. A fat person may lose weight with benefit and gain in general condition.

Although the extent of induration in the chancre is not any real criterion as to the severity or otherwise of the ensuing *constitutional* infection, I consider that it may indicate the power of local resistance and the phagocytic power of the individual, and that the variation in size of the discretely enlarged lymphatic glands is also a possible clue to individual resistance, since enlargements vary in size and nature in different individuals under identical conditions, but exercise partly explains the matting of the glands and the forming of a large single mass.

The persistence of indurated and enlarged lymphatic glands is a most valuable sign for the continuance, or otherwise, of a brisk mercurial course, especially by the inunction method combined with radiant light baths, or of a substituted mixed treatment. Until the induration and enlargement of the glands is thoroughly and permanently reduced in cases of secondary syphilis, there can be no question of a cessation of treatment, since these are very possibly the repositories of tertiary syphilis, and the toxins formed can no doubt give rise to parasyphilitic affections by travelling to the nervous system. Under efficient treatment these glands are reduced to normal in about six to nine months from the date of infection, but in some cases this

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<sup>1</sup> Advisory Board Report. “On Venereal Diseases in the Army.”

can naturally occur earlier and quite independently of treatment. Intramuscular injection of the *insoluble* grey oil is not nearly so useful for this purpose as inunction, hydrag. c̄ creta, &c. The lymphatic glands are ordinarily normal with tertiary lesions whether these occur within one year after infection, or later.

Slight albuminuria occurring as the direct result of syphilis is not a bar to the carefully watched administration of small doses of mercury, but a large amount of albumen, or albuminuria the result of nephritis from other causes, is a contraindication to the use of the drug. Severe anæmia occurring during the mercurial course counsels interruption, but it must be remembered that anæmia ordinarily occurs in untreated syphilis, in the late primary and early secondary stages of the disease, from the syphilis, *per se*, or from syphilitic fever, which amounts in many cases to a generalised septicæmic state. Mercury is often badly borne in syphilis associated with malaria, cachexia, scurvy, or tubercle. Nervous tremors occurring during a mercurial course contraindicate the continuance of the drug. Alcoholic subjects and persons with neurasthenic temperaments, epileptic fits, or a hereditary tendency to insanity, require great care. Cellulitis not infrequently attacks wounds or alcoholic syphilised subjects under active mercurial treatment, and sepsis may quickly occur after operation in the early stages, or as boils, without operation. Grave septicæmia occurs with necrosis of bone in tertiary phases, and treatment should then be directed to ordinary surgical procedure for the necrosis and secondarily to specific drugs.

Before iodide of potassium is administered, the question of renal sufficiency should be adequately gauged. If albumen is present, or the quantity of urine insufficient, the iodide eruptions are likely to occur, and hence the value of free dilution of the drug, together with hot-air baths, as these exercise a markedly beneficial effect on the kidneys and assist elimination by the skin. In the early secondary stages the use of this drug is often essential to dispel mucous patches and ulcers in the mouth and throat which mercury, in some instances, may only aggravate. In fact it is often as well to temporarily substitute potassium iodide for the mercury until the mouth lesions are well in hand, but local remedies usually effect a rapid cure. Iodide of potassium acts well with *soluble* injections.

The headache and osteoscopic pains of early syphilis may rapidly yield to potassium iodide alone, or in combination with mercury, and a pustular syphilitic rash is markedly benefited.

On the other hand, the drug may give rise to severe headache and cause a rash. Headaches, however, are often due to albumen in the urine as the result of syphilis, even when no drug has been given.

It is generally held that potassium iodide is in no sense a curative agent in syphilis, as is mercury, but the theories adduced in support of this view are only based on conjecture. There can be no question that this drug, through its power of removing the barricades of nascent fibrous tissue in which the syphilitic virus is ensconced, thereby permits the leucocytes, bathed in plasma and containing an opsonin, to enter, and so the syphilitic microbe is taken up or attenuated, and this explains the lessened anæmia of the patient. The drug has an undoubted beneficial effect in many phases of syphilis, and will succeed in effecting what mercury may fail in doing. It can rapidly remove severe manifestations and reduce enlarged glands. A drug that is capable of doing this is sufficiently curative to justify its more frequent employment in treating syphilis. Potassium iodide is more obviously beneficial the further the stage from primary infection, and its use, therefore, is imperative in the late secondary and tertiary stages, or in any manifestation, however early, such as malignant syphilis, presenting the attributes of those stages. It is wiser to prescribe it according to the late nature of the lesion rather than by a fixed time. Destructive lesions, when not due to early malignant virulence, ordinarily signify a low state of general health, and a lessened resistance which mercury may still further lessen. Potassium iodide is most valuable in every case of *early* syphilitic orchitis, in periostitis, nodes, gummata and gummatous ulcerations, in joint affections, and in threatened brain or cord lesions, and especially in cachectic cases, which may be syphilitic in origin, but are not infrequently mercurial.

Patients who are intolerant of small doses, such as gr. v., may sometimes take a large one with impunity and advantage. The drug is best borne about an hour after meals in *dilute* solution in such vehicles as water, milk, and sarsaparilla.

The depressant action of the drug is best avoided by prescribing it in ammonia solution, or by associated general tonic treatment and hot-air baths, and by administering the large dose at bed-time and avoiding its use in the morning. It is then not so likely to derange digestion or cause depression. Three to four weeks' administration and then intervals of rest ordinarily suffice. A course of a month once a year of gr. xv. to xxx. t.d.s.

is valuable as a precautionary measure in guarding against relapses and parasyphilitic affections, and is strongly recommended by Sir William Gowers.

The drug, as a matter of routine, should always be given as the complement of the mercurial course, since it is generally believed to assist the elimination of the accumulated mercury, and so guards against poisoning. It also acts, especially when combined with sarsaparilla, by relieving the liver and other viscera which are chronically congested, or lardaceous. The moderate use of the drug, therefore, causes a rapid elimination of the syphilitic poison and promotes a more healthy tone of the organs, which can then more naturally overcome the effects of the bacillus or its toxin. No doubt in certain cases of threatened brain syphilis, which have been neglected in the early stage, mercury may prove more valuable, but as a rule where severe tertiary manifestations are early apparent, as in *syphilis grave* or in *malignant* syphilis, mercury is often quite useless by itself, and it is the general condition that is the first consideration.

The Zittman treatment, which consists of mercury in minute doses, administered in a warm room, is most valuable in severe cases, by causing diaphoresis and purging, and so emptying the lymphatics, and in giving the blood containing the leucocytes a better chance of circulating. Hot air electric baths are not available in the Army even at large hospitals, but a course of these is very strongly advocated before commencing mercurial or other treatment in emaciated cases, or in dealing with men who have a large amount of albumen, and in the case of foreign invalids who not infrequently weigh under 100 pounds.

The seaside is excellent in cases of severe, destructive, or malignant syphilis. Patients do well at Netley, or on sea voyages, and can, when built up, often take remedies that they were previously unable to use. Damp heat such as exists at Alexandria, Aden, Rangoon, Bombay, Hong Kong, does not suit syphilitic cases like the dry heat at Mhow, Deesa, Kamptee, Deolalee, &c. The reason presumably is that damp as contrasted with dry heat causes a lowered general health, and syphilis thus gains a marked ascendancy.

Owing to the alleged fact that most of the dangerous symptoms in syphilis occur within the first three years, some authorities have recommended that *chronic intermittent* treatment should be continued for at least that period as a precautionary measure against tertiary manifestations, the case being kept under observation at any rate in the third year.

The ordinarily received opinion is, that a person should not marry until at least two years after the last seen secondary manifestations. This, then, if true, would appear to be a good guide to the best limit of time for treatment to continue in *acquired* syphilis. Fournier, in France, and other persons, state that syphilis is hereditarily transmissible during the first five years from contagion, and in isolated cases, after a longer period.

In the early secondary stage, when the disease is more manifest in the blood, syphilis is more communicable to the offspring. At this period the mucous plaques, patches, and condylomata, are most dangerous by direct contact; and in these lesions the *spirochæte pallida* is more superficial and more easily demonstrated. In malignant syphilis I have seen early tertiary destructive lesions in association with early secondary manifestations, and even with the primary chancre. Such cases would, I think, prove to be capable of infecting other persons.

It is generally allowed that syphilis is not transmissible in the tertiary stage; nor has the *spirochæte pallida* been as yet demonstrated in this phase of the disease. Cases, no doubt, vary in the time of arriving at the tertiary stage, but my personal experience is that one rarely sees purely *secondary* symptoms after one year, and this may be so even in untreated syphilis. This shows a natural tendency towards cure in syphilis, which is no doubt largely due to the increased activity of the leucocytes or to the formation of anti-bodies in the blood in average cases in good health, but inasmuch as *tertiary* symptoms can occur in syphilis despite treatment, we must not unduly flatter our specific remedies, but regard the tertiary lesion as the last effort of nature at elimination of the poison, and the localisation of the disease as a practical hint for the employment of local remedies as well as any methods whereby we can improve the general health and the capacity of the leucocyte.

Syphilitic lesions of the brain and cord are stated to occur in large numbers in the first three years (Colcott Fox, Second Report, Advisory Board). Although one meets with such cases, yet in my experience in military hospitals, when taken as a percentage, the numbers are well under 10 per cent., and probably very much less, but in the Army cases of syphilis usually receive early and prolonged treatment.

The abuse of alcohol plus sexual excess has, without doubt, an important subsidiary influence in parasyphilitic states. As, however, the proximal lymphatic glands are so very early infected in syphilis, the spinal cord and brain in the first instance

are no doubt directly influenced through lymphatic or nervous channels.

I do not concur in the opinion expressed by Colonel Lambkin, that "no advantage may be expected from other modes of treatment without mercury." It is generally admitted by writers on this subject that the very greatest advantage frequently accrues from the total cessation of mercury and the substitution of other tonic remedies. I think that this is more especially the case in alcoholic, scorbutic, anæmic, or tubercular subjects, and in malignant syphilis.

Quinine in dilute acid solution is often most valuable precedent to, or immediately after, the first mercurial course, and in cachectic cases. Whether it exerts a specific action on the spirochæte of syphilis, as on the malarial parasite, is uncertain, but I think it should be invariably given if there is an associated malarial history, or syphilitic fever. Such fever is common with the onset of rash, and in the later stages with the septicæmia due to the necrosing bone or tissues. As early syphilis is associated with a loss in numbers of the red-blood corpuscles and in the amount of the hæmoglobin in those cells, quite possibly its chief action may be in overcoming this degenerative action, and thus assisting the blood to better deal with the inroads of the virus in the early and more remediable phases of the disease, by increasing its phagocytic power, or by the formation of antibodies. Further, any drug which tends to reduce the number of spirochætes in the blood in the early stages, will consequently lessen the amount of toxin which can later injure the central nervous system and cord. Cod-liver oil and iron are similarly valuable for their hæmatinic properties.

The following remarks were published by the writer in 1898, and accentuated in a further article in 1903,<sup>1</sup> and they summarise former statements:—

"There is no class of disease in which the beneficent results of judicious and early treatment, or the pernicious results of injudicious and late treatment, are so marked as in syphilis. If the remedy used is doing good, the result is early apparent, and the manifestations of disease disappear: if, on the contrary, the manifestations are stationary, or growing progressively worse, the remedy is inadequate and fresh methods should be essayed, either by an increase or decrease of dose, or the substitution of other drugs and remedies.

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<sup>1</sup> "The Action of Drugs in Syphilis," King's College Hospital, London, Annual Report, 1903—H. C. F.

The application of the rules of antiseptic surgery to the wounds of syphilis is valuable in proportion to the extent and manner in which they are used.

Success more often depends on maintaining the strength by means of the judicious use of stimulants and nutritious food than on drugs. This is especially true in cases of iritis, severe throat lesions, and necrosis of bone.

If there are ulcers in the throat or mouth, a minced meat or stew diet is absolutely essential to successful treatment. Otherwise, the patient rapidly loses weight, if he is unable to masticate, or swallow, too solid food, and mercury would only aggravate matters.

A specific is generally understood to be a drug capable of acting on the virus of a disease. Do mercury, or iodide of potassium, act thus? By their depurative action on the lymphatic glandular system, and by their alterative and tonic effect on tissue change in general—whether it be mercury in a simple disease, as in cases of simple anæmia, or both drugs, as in a venereal disease—they remove the external manifestations, the symptoms of syphilis, but the mode of action is similar to that of nature, which can do this unassisted. The rash and other symptoms are mere phases in the process of evolution, and these drugs assist this natural process, but it is doubtful if they do more.

Syphilis is essentially a disease where we treat symptoms, and at the same time lay the flattering unction to our souls that we are treating the cause. Whether nature or our remedies take the larger share in obtaining success is immaterial, progress is the ultimate object of both.

It is always well, however, to bear in mind the Baconian maxim—"Let innovation be held for a suspect."

## APPENDIX 1.

- (1) THE DIAGNOSIS OF SYPHILIS. (2) THE "RELATIVE FREQUENCY" OF NON-INFECTING TO INFECTING CHANCRES (SYPHILIS). (3) THE FREQUENCY OF CONCEALMENT.

THE following is a personally collected record at Cairo, Egypt, in 1904, of 200 *in-patients* with *venereal sores*. These cases on discharge from hospital were kept under prolonged observation. There is a relative frequency of 3·5 "*non-infecting*" chancres to 1 of "syphilis," as there were 45 cases of syphilis. Induration was almost invariably present in the "syphilitic" chancres, as well as in the proximal inguinal glands, and was absent in "non-infecting" chancres (with very rare exceptions—pseudo-chancres indurés). There was either a discrete bullety enlargement, or a hyperplastic *non-suppurating* mass (bubo), which rarely ended in suppuration in the case of syphilis, and the amygdaloid or "bullet" nature of the *individual* glands could be later made out as the mass slowly subsided under treatment. These hyperplastic mattings in the groin usually resulted from concealment and active exercise in the chancre stage. The very common association of *suppurating* buboes with *non-infecting* sore commonly resulted from concealment, or from neglect in the *initial* stages, and necessitated a lengthened stay in hospital. The diagnosis of syphilis in this investigation was not finally made until the absolutely classical sign of syphilis, viz., rash, was apparent, but induration in the chancre plus bullet glands is ordinarily diagnostic of syphilis, as a close study of these cases will reveal. Further, the "proximal" inguinal glands were usually first enlarged. The bulk of the admissions appear to be very *young* soldiers within their *first year* of service in the command abroad, and frequently within the first few weeks.

The treatment in the case of syphilis usually consisted of inunctions, baths, dietary, and local measures in the earlier stage in hospital, and mercurial intramuscular injections for out-patients. There were over 100 men on the syphilis register during the period of the investigation, from December, 1903, to September, 1904. There were not any invalids from the station either for syphilis or gonorrhœa.

I have verified the above by a long similar series of recent investigations at Woolwich in 1905 to 1907.

TABULATED LIST OF 200 CASES TREATED  
AT CAIRO, IN 1904.

# APPENDIX I.

Hg = mercury; n = normal; ingl. = inguinal; pr. s. = primary syphilis; sec. s. = secondary (constitutional) syphilis.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
1	Pte. A. ..	24	5	1	Non-infecting chancre	16.10.03	7.1.04	Suppurating bubo, L.; cut; debility	83	No induration of chancre; no enlarged and indurated ( <i>i.e.</i> , "bullet") glands. No Hg. No sec. s.
2	" P. ..	24	5	$\frac{9}{1\frac{1}{2}}$	" "	12.11.03	6.1.04	Suppurating bubo, L.; cut	56	" " " "
3	" C. ..	28	7	$\frac{6}{1\frac{1}{2}}$	" "	24.12.03	28.1.04	Suppurating bubo, R.; cut	35	" " " "
4	" B. ..	22	4	1	" "	15.11.03	14.1.04	Suppurating bubo, R. and L.; cut	60	" " " "
5	" W. ..	24	6	1	" "	12.11.03	14.1.04	Suppurating bubo, R.; cut	63	" " " "
6	" J. ..	24	4	1	" "	18.11.03	28.1.04	" " " "	71	" " " "
7	" B. ..	19	1	$\frac{9}{1\frac{1}{2}}$	" "	18.12.03	27.3.04	Suppurating bubo, L.; cut; debility	99	" " " "
8	" A. ..	29	8	1	" "	1.12.03	5.1.04	Non-suppurating bubo, L. (hyperplastic mass)	36	" " " "
9	" F. ..	20	2	1	" "	27.12.03	14.1.04	" " " "	18	No induration of chancre; ingl. glands n. No Hg. No sec. s.
10	" D. ..	21	3	..	" "	26.12.03	28.3.04	Suppurating bubo, R.; cut Dec. 29, 1903; severe, sloughing phagedæna. ( <i>Concealment</i> )	92	No induration of chancre; ingl. glands; no "bullet" glands. No Hg. No sec. s. Case taken.
11	" D. ..	23	7	2 wks.	" "	3.12.03	7.1.04	" " " "	35	No induration of chancre; ingl. glands n. No Hg. No sec. s.
12	" C. ..	20	1	$\frac{2}{1\frac{1}{2}}$	" "	27.12.03	18.2.04	" " " "	53	" " " "
13	" W. ..	20	2	$\frac{8}{1\frac{1}{2}}$	" "	23.12.03	12.1.04	" " " "	20	" " " "
14	" W. ..	21	2	1	" "	15.12.03	28.3.04	Suppurating bubo, R.; cut; debility	103	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
15	" C. ..	22	2	1	" "	29.12.03	1.3.04	Suppurating bubo, L.; cut	61	" " " "

16	Pte. F.	..	23	3	$\frac{8}{1\frac{1}{2}}$	Non-infecting chancre	31.12.03	19.1.04	..	..	20	No induration of chancre; ingl. glands n. No Hg. No sec. s.
17	"	B.	23	4	$\frac{2}{1\frac{1}{2}}$	"	27.12.03	6.1.04	..	..	11	"
18	"	G.	22	4	$\frac{2}{1\frac{1}{2}}$	"	24.12.03	10.2.04	..	..	38	" induration of chancre; no "bullet" glands. No Hg. No sec. s.
19	"	W.	20	4	$\frac{8}{1\frac{1}{2}}$	"	10.12.03	22.1.04	..	..	44	No induration of chancre; ingl. glands n. No Hg. No sec. s.
20	"	C.	21	2	$\frac{1}{1\frac{1}{2}}$	"	13.12.03	11.2.04	Phimosis (circumcision)	..	61	"
21	"	C.	25	2	1	<i>Syphilis</i>	2.12.03	4.4.04	Inflammatory phimosis, severe, purulent discharge; necrosis of chancre, but not active phagedæna. ( <i>Concealed</i> )	..	125	" indurated chancre, raised, R. side, under phimosed foreskin; R. ingl. glands discrete, "bullet," enlarged. No Hg. in primary stage. Roseolar rash, Dec. 20, 1903. Case taken.
22	"	C.	22	6	$\frac{9}{1\frac{1}{2}}$	"	9.12.03	16.2.04	Warts and suppurating bubo, R.; cut. ( <i>Concealed</i> )	..	70	Chancre and warts, June 15, 1903; roseolar rash, July 6; Dec. 10, warts on penis and suppurating bubo R. cut; bubo L. subided. No Hg in primary stage. Case taken.
23	"	A.	24	5	$\frac{6}{1\frac{1}{2}}$	"	5.11.03	5.3.04	Suppurating bubo, R. and L.; cut in secondary stage. ( <i>Concealed</i> )	..	142	Indurated chancre, Nov. 5, 1903; double suppurating buboes in secondary stage; amygdaloid gland excised; L., Jan. 13, 1904; primary stage concealed. No Hg in primary stage. Roseolar rash, Nov. 5, 1903. Case taken.
24	"	C.	20	1	$\frac{2}{1\frac{1}{2}}$	Non-infecting chancre	1.1.04	2.2.04	..	..	33	No induration of chancre: ingl. glands n. No Hg. No sec. s.
25	"	S.	22	$\frac{4}{1\frac{1}{2}}$	$\frac{1}{1\frac{1}{2}}$	"	2.1.04	22.1.04	..	..	21	"
26	"	S.	22	5	1	"	4.1.04	30.1.04	..	..	27	"
27	"	M.	22	3	1	"	8.1.04	20.2.04	Suppurating bubo, R.; cut	..	44	" induration of chancre; no "bullet" glands. No Hg. No sec. s.
28	"	W.	26	7	1	"	8.1.04	4.4.04	"	"	88	"
29	Dr. L.	..	19	1	$\frac{3}{1\frac{1}{2}}$	"	12.1.04	1.2.04	..	..	21	No induration of chancre; ingl. glands n. No Hg. No sec. s.
30	Pte. B.	..	19	$\frac{11}{1\frac{1}{2}}$	$\frac{1}{1\frac{1}{2}}$	"	12.1.04	1.2.04	Gonorrhœa	..	21	"
31	"	S.	24	6	1	"	14.1.04	27.1.04	Non-suppurating hyperplastic mass; L. ingl. glands	..	14	" induration of chancre (no "bullet" glands on subsidence of mass). No Hg. No sec. s.
32	Lance-Corpl. W.	..	22	1	$\frac{4}{1\frac{1}{2}}$	"	16.1.04	19.2.04	..	..	35	Three sores, no induration: "resilient" ingl. glands, but no "bullet" glands ( <i>vide</i> 67). Case taken.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
60	Pte. P. . .	26	4	1	Non-infecting chancre	22.3.04	19.4.04	Non-suppurating bubo, L.; hyperplastic mass on admission. ( <i>Concealment on manoeuvres</i> )	29	No induration of chancre; ingl. glands, no "bullet" glands on subsidence of mass. No Hg. No sec. s.
61	Sergt. P. . .	29	7	1 $\frac{5}{12}$	"	22.3.04	2.5.04	Congenital phimosi severe. ( <i>Concealment</i> )	42	No induration of chancre; ingl. glands n. No Hg. No sec. s. Case taken.
62	Pte. D. . .	24	5	5 $\frac{1}{2}$	"	25.3.04	2.6.04	Phimosi, inflammatory; phagedæna; suppurating bubo, L.; cut. ( <i>Concealment</i> )	70	No induration of chancre; ingl. glands, no "bullet" glands. No Hg. No sec. s. Case taken.
63	Lance-Corpl. M. . .	23	4	4 $\frac{1}{12}$	"	28.3.04	14.5.04	Suppurating bubo, L.; burst on admission. ( <i>Concealment</i> )	48	No induration of chancre; ingl. glands, no "bullet" glands. No Hg. No sec. s. (two sores).
64	Sapper O'M. . .	24	3	3	"	29.3.04	18.4.04	"	21	No induration of chancre; ingl. glands n. No Hg. No sec. s.
65	Lance-Corpl. B. . .	29	10	1 $\frac{1}{12}$	<i>Syphilis</i>	1.4.04	18.4.04	Non-suppurating hyperplastic mass, R.; ingl. glands. ( <i>Concealment</i> )	18	Connections March 1 and March 20, 1904; small ulcer noticed frænum, March 27; hyperplastic matting, R. ingl. glands "bul-lety"; induration appeared in the chancre after resolution. No Hg. in primary stage. Roseolar rash June 14; slightly infiltrated type and symmetrical typical ingl. adenitis. Case taken.
66	Corporal W. . .	24	5	1 $\frac{5}{12}$	"	6.4.04	14.7.04	Non-suppurating hyperplastic mass, L. ingl. glands	100	Connection March 15, 1904; ulcer evident April 1; Hunterian induration; discoid mass corona glandis; indurated amygdaloid glands in the mass. No Hg. in primary stage; roseolar rash May 9, 1904; papular rash May 29; ulcers both tonsils. Case taken.

67	Lance-Corpl. W...	22	1	$1\frac{5}{12}$	Non-infecting chancre	27.3.04	18.4.04	Bubo both groins; non- suppurating hyper- plastic mass	23	Frenal ulcer; relapse (?) No Hg. <i>Vide</i> No. 32. Case taken.
68	Gunner D.	20	$1\frac{9}{12}$	$3\frac{1}{12}$	<i>Syphilis</i>	2.4.04	14.4.04	.. ..	13	Connection March 15, 1904. He states that ulcer appeared March 29 on roll of prepuce, reverted L. side; indurated slight discrete enlargement L. ingl. glands. No Hg in primary stage. Roseolar rash May 11, slightly infiltrated type; roseolous throat. Case taken.
69	Pte. D.	25	5	$1\frac{3}{12}$	Non-infecting chancre	7.4.04	14.5.04	Suppurating bubo, L., on admission; cut. ( <i>Concealment</i> )	38	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
70	Gunner H.	$20\frac{4}{12}$	1	$4\frac{1}{12}$	"	11.4.04	30.6.04	Suppurating bubo, R.; cut	81	" "
71	Pte. S.	28	9	1	"	11.4.04	14.5.04	Suppurating bubo on admission; cut. ( <i>Con- cealment</i> )	34	" "
72	" M.	22	4	$5\frac{1}{12}$	"	12.4.04	23.4.04	Bubo L. groin on admis- sion; non-suppurating hyperplastic mass. ( <i>Concealment</i> )	12	No induration of chancre; no "bullet" glands on subsidence of mass as in syphilis. No Hg. No sec. s.
73	" J.	23	4	$6\frac{1}{12}$	"	14.4.04	19.5.04	Suppurating bubo, L., on admission; cut. ( <i>Con- cealment</i> )	36	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
74	" L.	25	5	$1\frac{4}{12}$	"	14.4.04	23.4.04	.. ..	10	No induration of chancre; ingl. glands n. No Hg. No sec. s.
75	" M.	$26\frac{8}{12}$	8	$4\frac{1}{12}$	"	16.4.04	28.5.04	.. ..	43	No induration of chancre; ingl. glands n. No Hg. No sec. s. Three sores.
76	" M.	20	1	$3\frac{1}{12}$	"	16.4.04	14.5.04	.. ..	29	No induration of chancre; ingl. glands n. No Hg. No sec. s.
77	" P.	24	6	$1\frac{6}{12}$	"	17.4.04	2.6.04	Suppurating bubo, R.; cut	47	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
78	" M.	28	9	$6\frac{1}{12}$	"	18.4.04	28.5.04	.. ..	41	No induration of chancre; ingl. glands n. No Hg. No sec. s. Fissured sore.
79	" P.	23	5	$1\frac{5}{12}$	"	16.4.04	16.6.04	Suppurating bubo, L., on admission. ( <i>Con- cealment</i> )	62	No induration of chancre. No "bullet" glands. No Hg. No sec. s.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
60	Pte. P. ..	26	4	1	Non-infecting chancre	22.3.04	19.4.04	Non-suppurating bubo, L.; hyperplastic mass on admission. ( <i>Concealment on manoeuvres</i> )	29	No induration of chancre; ingl. glands, no "bullet" glands on subsidence of mass. No Hg. No sec. s.
61	Sergt. P. ..	29	7	1½	" "	22.3.04	2.5.04	Congenital phimosi severe. ( <i>Concealment</i> )	42	No induration of chancre; ingl. glands n. No Hg. No sec. s. Case taken.
62	Pte. D. ..	24	5	½	" "	25.3.04	2.6.04	Phimosi, inflammatory; phagedæna; suppurating bubo, L.; cut. ( <i>Concealment</i> )	70	No induration of chancre; ingl. glands, no "bullet" glands. No Hg. No sec. s. Case taken.
63	Lance-Corpl. M...	23	4	½	" "	28.3.04	14.5.04	Suppurating bubo, L.; burst on admission. ( <i>Concealment</i> )	48	No induration of chancre; ingl. glands, no "bullet" glands. No Hg. No sec. s. (two sores).
64	Sapper O'M. ..	24	3	3	" "	29.3.04	18.4.04	.. .. .	21	No induration of chancre; ingl. glands n. No Hg. No sec. s.
65	Lance-Corpl. B...	29	10	½	<i>Syphilis</i> ..	1.4.04	18.4.04	Non-suppurating hyperplastic mass, R.; ingl. glands. ( <i>Concealment</i> )	18	Connections March 1 and March 20, 1904; small ulcer noticed frænum, March 27; hyperplastic matting, R. ingl. glands "bul-lety"; induration appeared in the chancre after resolution. No Hg. in primary stage. Roseolar rash June 14; slightly infiltrated type and symmetrical typical ingl. adenitis. Case taken.
66	Corporal W. ..	24	5	1½	" "	6.4.04	14.7.04	Non-suppurating hyperplastic mass, L. ingl. glands	100	Connection March 15, 1904; ulcer evident April 1; Hunterian induration; discoid mass corona glandis; indurated amygdaloid glands in the mass. No Hg. in primary stage; roseolar rash May 9, 1904; papular rash May 29; ulcers both tonsils. Case taken.

67	Lance-Corpl. W...	22	1	$\frac{5}{1\frac{1}{2}}$	Non-infecting chancre	27.3.04	18.4.04	Bubo both groins; non-suppurating hyperplastic mass	23	Frænal ulcer; relapse (?) No Hg. No. 32. Case taken.
68	Gunner D.	20	$1\frac{9}{12}$	$\frac{3}{1\frac{1}{2}}$	<i>Syphilis</i>	2.4.04	14.4.04	.. ..	13	Connection March 15, 1904. He states that ulcer appeared March 29 on roll of prepuce, reverted L. side; indurated slight discrete enlargement L. ingl. glands. No Hg in primary stage. Roseolar rash May 11, slightly infiltrated type; roseolous throat. Case taken.
69	Pte. D.	25	5	$1\frac{3}{1\frac{1}{2}}$	Non-infecting chancre	7.4.04	14.5.04	Suppurating bubo, L., on admission; cut. ( <i>Concealment</i> )	38	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
70	Gunner H.	$20\frac{4}{12}$	1	$\frac{4}{1\frac{1}{2}}$	"	11.4.04	30.6.04	Suppurating bubo, R.; cut	81	" " " "
71	Pte. S.	28	9	1	"	11.4.04	14.5.04	Suppurating bubo on admission; cut. ( <i>Concealment</i> )	34	" " " "
72	" M.	22	4	$\frac{5}{1\frac{1}{2}}$	"	12.4.04	23.4.04	Bubo L. groin on admission; non-suppurating hyperplastic mass. ( <i>Concealment</i> )	12	No induration of chancre; no "bullet" glands on subsidence of mass as in syphilis. No Hg. No sec. s.
73	" J.	23	4	$\frac{6}{1\frac{1}{2}}$	"	14.4.04	19.5.04	Suppurating bubo, L., on admission; cut. ( <i>Concealment</i> )	36	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
74	" L.	25	5	$1\frac{4}{1\frac{1}{2}}$	"	14.4.04	23.4.04	.. ..	10	No induration of chancre; ingl. glands n. No Hg. No sec. s.
75	" M.	$26\frac{8}{12}$	8	$\frac{4}{1\frac{1}{2}}$	"	16.4.04	28.5.04	.. ..	43	No induration of chancre; ingl. glands n. No Hg. No sec. s. Three sores.
76	" M.	20	1	$\frac{3}{1\frac{1}{2}}$	"	16.4.04	14.5.04	.. ..	29	No induration of chancre; ingl. glands n. No Hg. No sec. s.
77	" P.	24	6	$1\frac{6}{12}$	"	17.4.04	2.6.04	Suppurating bubo, R.; cut	47	No induration of chancre; no "bullet" glands. No Hg. No sec. s.
78	" M.	28	9	$\frac{6}{1\frac{1}{2}}$	"	18.4.04	28.5.04	.. ..	41	No induration of chancre; ingl. glands n. No Hg. No sec. s. Fissured sore.
79	" P.	23	5	$1\frac{5}{12}$	"	16.4.04	16.6.04	Suppurating bubo, L., on admission. ( <i>Concealment</i> )	62	No induration of chancre. No "bullet" glands. No Hg. No sec. s.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
80	Pte. W. . .	21	6	1½	<i>Syphilis</i> . .	19.1.04	18.3.04	Non-suppurating hyperplastic matting L. ingl. glands. ( <i>Concealed</i> )	60	Connection every week; ulcer noticed Nov. 14, 1903; on Jan. 19, 1904, typical Hunterian collar-like induration situated on roll of prepuce, reverted R. side; ingl. glands discretely enlarged and "bullet"; non-suppurating matting L. ingl. glands; small papular rash since Jan. 16, profuse, generalised, severe. No Hg. in primary stage. Concealed. Case taken.
81	„ McQ. . .	23	2	4½	„ „	18.2.04	14.5.04	.. ..	87	Connection, Feb. 1, 1904 (pay day); papule, Feb. 13, which enlarged, became indurated and ulcerated, Feb. 22; typical Hunterian induration L. side, Mar. 7; the left ingl. glands are now typically "bullet" and enlarged, one amygdaloid. No Hg in primary stage. Roseolar rash, March 23, non-infiltrated type. Case taken.
82	„ B. . .	24	4	1½	„ „	30.12.03	10.3.04	Severe inflammatory phimosi; no phagedæna; non-suppurating hyperplastic matting R. ingl. glands. ( <i>Concealment</i> )	71	Connection, Dec. 7, 1903. Ulcer under prepuce of some days' duration on admission, Dec. 30; induration in chancre, Jan. 18, 1904; R. ingl. glands, amygdaloid gland; L. ingl. later "bullet" and discretely enlarged. No Hg in primary stage. Roseolar rash, Jan. 24, slightly infiltrated type. Case taken.
83	„ M. . .	19	1	..	„ „	5.2.04	8.4.04	Non-suppurating hyperplastic matting L. ingl. glands	63	Connection, Nov. 21, 1903. Ulcer noticed, Nov. 26; hospital at Jersey, Nov. 28, resolved, relapsed, obviously indurated, Dec. 21; Hunterian induration, L. side of roll of prepuce reverted; left ingl. glands discrete, "bullet," enlarged; R. later so on Dec. 28; Roseolar rash, Dec. 28, non-infiltrated type.

84	Pte. T.	..	23	4	1	<i>Syphilis</i>	..	20.1.04	20.5.04	Non-suppurating hyper-plastic matting R. ingl. glands	126	Connection, Jan. 12, 1904. Admitted hospital gonorrhoea, Jan. 20, and R. ingl. glands swollen, discretely enlarged and painful, later matting; Feb. 16, minute white blister on roll of prepuce reverted; L. side ulcerated; slight induration, Feb. 27; both ingl. chains and femoral glands indurated; Roseolar rash, March 27; large papular (flat), April 8. No Hg in primary stage. Case taken.
85	Lance-Corpl. M...	..	23	4	$1\frac{4}{12}$	..	..	19.3.04	14.5.04	( <i>Concealment</i> )	57	Connection, Feb. 1 and 26, 1904. Papule, March 5, enlarged, indurated, ulcerated; on March 19, large indurated Hunterian chancre, roll of prepuce reverted near frænum; R. ingl. glands enlarged and "bullet," L. slightly so; roseolar rash, March 19, slightly infiltrated type. Case taken.
86	Pte. B.	..	23	4	$1\frac{6}{12}$	Non-infecting chancre	..	20.3.04	2.5.04	.. .. ..	44	No induration of chancre; ingl. glands n. No Hg. No sec. s.
87	" B.	..	23	3	$1\frac{7}{12}$	" "	" "	14.4.04	19.5.04	Bubo, R., on admission, non-suppurating hyper-plastic mass. ( <i>Concealment</i> )	36	No induration of chancre; no discrete, "bullet," enlarged glands on subsidence of mass as in syphilis. No Hg. No sec. s.
88	" T.	..	25	5	$1\frac{4}{12}$	<i>Syphilis</i>	..	22.4.04	9.7.04	( <i>Concealed</i> ). Phagedæna	79	Connection, Jan. 2, 1904, Cairo. Chancre concealed; he admits rash, March 20, on calves of legs. April 22, admitted hospital. Resolving chancre on glans penis; symmetrical, severe ingl. adenitis, "bullet," &c.; large flat papular rash, very severe; ulcers both tonsils; onychia, phagedæna, anæmia; wt. 8 st. 10 lb. Case taken.
89	" E.	..	22	3	$1\frac{9}{12}$	Non-infecting chancre	..	25.2.04	2.5.04	.. .. ..	68	Pseudo-chancre induré. No sec. s. Case taken.
90	" M.	..	24	4	$1\frac{9}{12}$	" "	" "	28.2.04	2.5.04	.. .. ..	65	Pseudo-chancre induré. <i>Vide</i> 137. No sec. s. Case taken.
91	" S.	..	24	4	$\frac{5}{12}$	" "	" "	3.7.04	1.8.04	Suppurating bubo, R., on admission. ( <i>Concealment</i> )	33	No induration of chancre; "resilient" enlargement; L. ingl. glands. No Hg. No sec. s.
91	"	..						28.4.04	30.5.04			

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
92	Pte. McK.	29	..	7½	Syphilis	28.4.04	30.6.04	Concealment ..	64	Connection, March 7, 1904, and ulcer observed by patient, April 14; admitted hospital, April 28. Hunterian collar-like induration ¾ inch long, roll of prepuce reverted left side; both ingl. chains discretely enlarged and "bullet." No Hg in primary stage. Roseolar rash, May 4; later large flat papular, May 12, and mucous patches. Case taken.
93	" S.	21	1	6½	"	29.4.04	30.5.04	Concealment ..	32	Connection, March 5, 1904. Ulcer evident about April 5; on admission to hospital, April 29, large indurated Hunterian chancre right of frænum; both ingl. glands discretely and considerably enlarged and "bullet," Ung. Hg inunctions, May 1. Roseolar rash, July 1, 1905; non-infiltrated type, four days' duration. Case taken.
94	" Y.	28	2	1½	Molluscum contagiosum	3.5.04	8.5.04	.. ..	5	Two pearly typical <i>Mollusca contagiosa</i> on external surface of prepuce.
95	" B.	20	1	4½	Non-infecting chancre	6.5.04	30.6.04	.. ..	56	Multiple chancres (2), one fissured on roll of prepuce, left, six weeks healing; no induration; resilient enlargement L. ingl. glands. No Hg. No sec. s.
96	Lance-Corpl. E...	21	3	1½	"	6.5.04 8.7.04	19.5.04 23.7.04	.. ..	14 16	No induration of chancre; ingl. glands n.; frænal ulcer, fissured type, single. Relapsed he states on re-admission, July 8, 1904 (probably fresh infection).

97	Pte. H. . .	..	23	5	$\frac{6}{1\frac{1}{2}}$	Non-infecting chancre	7.5.04 22.7.04	2.6.04	Suppurating bubo R.; cut, July 22, 1904	27	No induration of chancre; no "bullet" glands; single ulcer left of frænum on admission; a second ulcer R. of frænum developed, May 25, 1904. No sec. s. Re- admitted July 22, fresh infection. Soft chancre; suppurating bubo, R.; cut. No sec. s. In hospital, August 20.
98	" B. . .	..	21	2	$\frac{5}{1\frac{1}{2}}$	" "	7.5.04	21.6.04	Suppurating bubo, L., on admission; cut. <i>Concealment</i>	46	No induration of chancre near frænum (multiple 2); ingl. glands; no "bullet" glands. No Hg. No sec. s.
99	" M. . .	..	19	1	$\frac{5}{1\frac{1}{2}}$	" "	8.5.04	11.6.04	Phimosis, inflammatory, on admission; slough- ing phagedæna. ( <i>Con- cealment</i> )	35	No induration of chancre; slight resilient enlargement of L. ingl. glands; hyper- plastic matting of R. ingl. glands; single chancre on external surface of dorsum of penis; polycyclical outline as in gumma- tous ulcers. No sec. s. Case taken.
100	" W. . .	..	20	$1\frac{1}{2}$	$\frac{3}{1\frac{1}{2}}$	" "	8.5.04	2.6.04	Inflammatory phimosis, severe. ( <i>Concealment</i> )	26	No induration of chancre; multiple; four; ingl. glands n. No Hg. No sec. s.
101	Lce.-Corpl. McA.	McA.	23	5	$\frac{5}{1\frac{1}{2}}$	<i>Syphilis</i> ..	17.4.04	18.6.04	.. .. ..	63	Connection, March 23, 1904. Ulcer stated to have appeared April 10; admitted, April 17; fissured indurated chancre centrally on frænum; "bullet" buboes L. ingl. only. No Hg in primary stage. Papular rash (small, round and acneform), May 12. Ung. Hg inunction, May 12, and K. I. by mouth. Case taken.
102	Pte. C. . .	..	22	4	$\frac{5}{1\frac{1}{2}}$	Non-infecting chancre	11.5.04	19.5.04	.. .. ..	9	No induration of chancre; ingl. glands n.; multiple chancres (four). No Hg. No sec. s.
103	" W. . .	..	22	3	$\frac{7}{1\frac{1}{2}}$	" "	13.5.04	14.6.04	Suppurating bubo, R., on admission. ( <i>Con- cealment</i> )	33	No induration of chancre; no "bullet" glands; two small ulcers near frænum. No Hg. No sec. s.
104	" McC.	..	21	1	$\frac{7}{1\frac{1}{2}}$	" "	14.5.04 4.6.04	2.6.04 7.7.04	.. .. ..	20 34	No induration of chancre; ingl. glands n.; single, under surface of prepuce, dorsal aspect of penis. Relapsed, June 4, 1904; no induration. No Hg. No sec. s.
105	Gunner K.	..	21	2	1	" "	15.5.04	16.7.04	Non-suppurating bubo, L., on admission. ( <i>Con- cealment</i> )	63	No induration of chancre; no "bullet" glands on subsidence of mass; single ul- cer, roll of prepuce, L. side; no sec. s.

# APPENDIX 1.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
106	Pte. T. ..	22	1	$\frac{5}{1\frac{1}{2}}$	Non-infecting chancre	17.5.04 7.6.04 8.7.04	2.6.04 20.6.04 23.7.04	Gleet (gonorrhœal conjunctivitis)	17 14 16	No induration of chancre; ingl. glands n.; single ulcer, roll of prepuce, L. No Hg. No sec. s.; gonorrhœa, June 7, also another soft chancre. Case taken.
107	" P. ..	23 $\frac{6}{1\frac{1}{2}}$	2	$\frac{5}{1\frac{1}{2}}$	"	17.5.04	28.5.04	"	12	No induration of chancre; ingl. glands n.; single small ulcer. No Hg. No sec. s.
108	" F. ..	19	$\frac{10}{1\frac{1}{2}}$	$\frac{3}{1\frac{1}{2}}$	"	15.5.04	2.6.04	"	19	"
109	" C. ..	21	2	$\frac{1}{1\frac{1}{2}}$	"	22.5.04	7.7.04	"	47	"
110	" C. ..	21 $\frac{6}{1\frac{1}{2}}$	3	$1\frac{6}{1\frac{1}{2}}$	"	23.5.04	11.6.04	"	20	No induration of chancre; ingl. glands n.; multiple ulcers (three). No Hg. No sec. s.
111	" B. ..	23	1	$\frac{7}{1\frac{1}{2}}$	"	24.4.04	24.5.04	Suppurating bubo, R.; cut	31	No induration of chancre; no induration of ingl. glands; single sore. No Hg. No sec. s.
112	Gunner A. ..	25	5	$1\frac{6}{1\frac{1}{2}}$	"	24.5.04	30.6.04	Non-suppurating bubo, L. (hyperplastic mass)	38	No induration of chancre; no "bullet" glands on subsidence of mass; single sore on roll of prepuce. No Hg. No sec. s. Case taken.
113	Dr. H. ..	20	2	$1\frac{6}{1\frac{1}{2}}$	<i>Syphilis</i> ..	24.5.04	18.8.04	Inflammatory phimosis; cellulitis; no phagedæna; hyperplastic non-suppurating matting, R. ingl. glands. ( <i>Concealment</i> )	87	Connection early in April, he states; ulcer noticed early in May, he states (?). On admission, May 24, 1904, large indurated Hunterian chancre, roll of prepuce inverted; R. side, cellulitis of prepuce, extending on to scrotum and thighs; non-suppurating matting and bubo, R. ingl. glands. Ung. Hg inunctions, May 25. Generalised eczematous rash; papular rash, June 16. Case taken.

114	Pte. W. ..	22	3	$2\frac{5}{1\frac{1}{2}}$	<i>Syphilis</i> ..	19.3.04	28.5.04	Erratic chancre on tonsil	71	Connection, Dec. 26, 1903; he states ulcer appeared on R. tonsil March 1, 1904 (hospital); admitted hospital, March 19; Large ragged ulcer R. tonsil; submaxillary gland, R. side, size of almond; he was isolated for measles. No Hg in primary stage; roseolar rash, April 12, infiltrated type, and generalised adenitis. Case taken.
115	Pte. C. ..	30	10	$1\frac{3}{1\frac{1}{2}}$	„	2.6.04	9.7.04	<i>Concealment</i> ..	38	Connection, May 1, 1904. He states (?) ulcer appeared May 5; admitted hospital, June 2; large Hunterian chancre, both ingl. marked adenitis, general adenitis, and roseolar rash, infiltrated type, seven days' duration. No Hg in primary stage. Hg inunctions, June 4. Case taken.
116	„ P. ..	22	4	$1\frac{5}{1\frac{1}{2}}$	„	3.6.04 1.8.04	1.7.04	.. ..	29	Connection, May 26, 1904; mixed ulcer on frænum appeared June 2; induration appeared June 30 on resolution. On this date L. ingl. glands discretely enlarged and shotty, but not very typical; frænal ulcer relapsed, Aug. 1; small papular rash (aeneform), Aug. 4, &c. No Hg in primary stage. Case taken.
117	Bandsman G. ..	21	3	$\frac{7}{1\frac{1}{2}}$	„	3.6.04	14.7.04	<i>Concealment</i> ..	42	Connection, April, 1904; ulcer appeared and concealed; admitted hospital June 3; indurated chancre size of a pea near left side of frænum; symmetrical ingl. and generalised adenitis, roseolar rash, June 3, non-infiltrated type, and ulcers on tonsils. No Hg in primary stage. Case taken.
118	Pte. D. ..	28	7	$\frac{7}{1\frac{1}{2}}$	Herpes penis	3.6.04	14.6.04	.. ..	12	Severe; grouped herpetic vesicular eruption, dorsal aspect of glans penis. No Hg. No sec. s.
119	Gunner G. ..	23	1	$\frac{3}{1\frac{1}{2}}$	Non-infecting chancre	4.6.04	14.7.04	.. ..	41	No induration of chancre; no induration or enlargement of ingl. glands; single sore. No Hg. No sec. s. Case taken.
120	Pte. Q. ..	20	$\frac{11}{1\frac{1}{2}}$	$\frac{2}{1\frac{1}{2}}$	„	5.6.04	19.8.04	.. ..	76	No induration of chancre; no induration or enlargement of ingl. glands; two ulcers, one large, on frænum; very slow healing, ten weeks. No Hg. No sec. s.

APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
121	Pte. G. ..	25	6	$1\frac{1}{2}$	Non-infecting chancre	6.6.04	23.6.04	.. .. .	18	No induration of chancre; no induration or enlargement of ingl. glands; three small ulcers, circular. No Hg. No sec. s.
122	Lance-Corpl. D...	22	5	$1\frac{1}{2}$	„ „	6.6.04	7.7.04	.. .. .	32	No induration of chancre; frænal ulcer single; no induration or enlargement of ingl. glands. No Hg. No sec. s.
123	Dr. L. ..	20	1	$1\frac{1}{2}$	„ „	7.6.04	18.6.04	.. .. .	12	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. ( <i>vide</i> 195).
124	Pte. G. ..	25	5	$1\frac{1}{2}$	„ „	18.6.04	23.7.04	Suppurating bubo, L. groin, on admission; cut. ( <i>Concealment</i> )	36	No induration of chancre; no induration or enlargement of ingl. glands; three small ulcers under surface roll of prepuce. No Hg. No sec. s.
125	Gunner H. ..	20	3	$2\frac{3}{4}$	<i>Syphilis</i> ..	16.6.04	23.7.04	<i>Concealment</i> .. ..	38	Connection, April 20, 1904; ulcer noticed about May 15 he states. Admitted hospital, June 16; chancre resolved, but linear indurated cartilaginous cicatrix, roll of prepuce reverted R. side. Symmetrical ingl. adenitis, others normal; small round papular rash, &c. No Hg in primary stage; inunctions, June 19. Case taken.
126	Corpl. B...	22	3	$1\frac{9}{12}$	„ ..	19.6.04	..	„ .. .	..	Connection, April 19, 1904; ulcer noticed May 7, 1904; admitted hospital, June 19; small indurated Hunterian chancre; roll of prepuce reverted, R. side; generalised symmetrical severe adenitis; large papular rash (since June 1, he states). No Hg in primary stage; Hg inunctions, June 20; in hospital, Aug. 20. Case taken.

127	Corpl. W.	..	26	4	$1\frac{3}{12}$	Non-infecting chancre	21.6.04	..	Suppurating bubo, R., on admission; cut, July 4. ( <i>Concealment</i> )	..	No induration of chancre; no induration or enlargement of ingl. glands; single ulcer under surface of roll of prepuce, dorsal aspect. No Hg. No sec. s. Still in hos- pital, Aug. 20.
128	Pie. R.	..	20	1	$\frac{8}{12}$	"	23.6.04	1.7.04	..	9	No induration of chancre; no induration or enlargement of ingl. glands; six small circular ulcers. No Hg. No sec. s.
129	" G.	..	24	4	$\frac{8}{12}$	<i>Syphilis</i>	25.6.04	18.8.04	Severe inflammatory phimosis of prepuce; necrosis but no active phagedæna of chancre; non-suppurating hy- perplastic matting, R. ingl. glands. ( <i>Conceal- ment</i> )	55	Connection, May 24, 1904; ulcer noticed June 16, admitted hospital June 25; two Hunterian indurated chancres (commenced as papules) on either side of roll of prepuce reverted; both chains of ingl. glands dis- cretely enlarged and "bullet"; amygdal- oid, the R. later matted. No Hg in pri- mary stage. Roseolar rash, July 10, 1904; papular (acneform), July 15. Hg inunc- tions, July 13. Case taken.
130	" McA.	..	22	4	$\frac{8}{12}$	Non-infecting chancre	25.6.04	16.7.04	..	22	No induration of chancre; no induration or enlargement of ingl. glands; two small circular ulcers, roll of prepuce, L. side.
131	" L.	..	29	9	1	<i>Syphilis</i>	26.6.04	29.7.04	..	34	Connection, May 5, 1904; ulcer noticed June 17; admitted hospital June 26; commencing induration in large Hunterian chancre on roll of prepuce reverted L. side, cartila- ginous, July 4; L. ingl. glands, one amyg- daloid gland, and dorsal lymphatic of penis markedly enlarged, June 26. No Hg in primary stage. Roseolar rash, July 6; in- filtrated type. Inunctions Hg, July 10. Case taken.
132	" E.	..	24	1	$\frac{4}{12}$	Non-infecting chancre	17.6.04	17.7.04	..	31	No induration of chancre; no induration, but resilient enlargement of both ingl. glands. No Hg. No sec. s.; multiple chancre; seven minute circular ulcers.
133	" H.	..	25	3	$1\frac{9}{12}$	"	28.6.04	7.7.04	..	10	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. Multiple chancres; three small ulcers, depressed base.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
134	Pte. D. ..	21	3	1 $\frac{9}{12}$	Non-infecting chancre	1.7.04	16.7.04	.. .. .	16	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. Single small ulcer, depressed base, centrally situated, roll of prepuce.
135	„ McA. ..	22	3	1 $\frac{9}{12}$	„ „	2.7.04	18.8.04	Non-suppurating bubo, R. (hyperplastic mass)	48	No induration of chancre; no induration or “bullet” ingl. glands. No Hg. No sec. s. Multiple; six small chancroids.
136	„ B. ..	19	1	1 $\frac{6}{12}$	„ „	3.7.04	12.8.04	Suppurating bubo, R., on admission; cut, July 7. ( <i>Concealment</i> )	41	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. Single ulcer on frænum.
137	„ M. ..	24	4	1 $\frac{6}{12}$	„ „	3.7.04	1.8.04	.. .. .	30	Pseudo-chancere induré ( <i>vide</i> 90). Case taken.
138	„ W. ..	23	4	1 $\frac{8}{12}$	„ „	5.7.04	14.7.04	.. .. .	10	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. Single small white excoriation (blister) with later ulceration. Situated on roll of prepuce reverted.
139	Lance-Corpl. C...	20	2	1 $\frac{4}{12}$	„ „	1.7.04	1.8.04	.. .. .	32	No induration of chancre; no induration or enlargement of ingl. glands. No Hg. No sec. s. Three minute white excoriations (blisters), in size that of three pins' heads; later ulcer, under surface of roll of prepuce, L. side.
140	Pte. S. ..	23	2	1 $\frac{4}{12}$	„ „	26.6.04	7.7.04	.. .. .	12	No induration of chancre; both ingl. chains resiliently enlarged; No Hg. No sec. s. Single ulcer under surface of roll of prepuce.
141	„ L. ..	22	2	1 $\frac{7}{12}$	„ „	7.6.04	7.7.04	.. .. .	31	No induration of chancre; slight resilient enlargement of both ingl. glands. No Hg. No sec. s. Two small ulcers near frænum.

142	Pte. G.	..	21	4	$\frac{8}{1\frac{1}{2}}$	Non-infecting chancre	21.6.04	7.7.04	Gleet for 15 months ..	17	No induration of chancre; ingl. glands n. No Hg. No sec. s. Single ulcer under sur- face roll of prepuce, R. side.
143	" J.	..	19	1	$\frac{6}{1\frac{1}{2}}$	<i>Syphilis</i> .. ? Enteric fever	7.7.04 6.8.04	1.8.04	Urethral discharge	26	Admitted, July 7; urethral discharge; single ulcer, roll of prepuce, reverted, L. side. L. ingl. glands, one large indurated amy- daloid gland. No Hg in primary stage. Discharged hospital, Aug. 1; re-admitted hospital, Aug. 6; fever and "spots," dia- gnosed "enteric fever"; temperature sub- sided by lysis, and normal on Aug. 15 (? syphilitic roseola).
144	" M.	..	29	11	$\frac{9}{1\frac{1}{2}}$	Non-infecting chancre	20.6.04	4.8.04	Hyperplastic non-sup- purating matting, L. ingl. glands	46	No induration of chancre; resilient enlarge- ment of ingl. glands, but no "bullet" glands of syphilis. No Hg. No sec. s.
145	Corpl. M.	..	29	10	$\frac{9}{1\frac{1}{2}}$	" "	9.7.04	4.8.04	.. ..	27	No induration of chancre (inflammatory thickening); frænal ulcer, single; ingl. glands n. No Hg. No sec. s.
146	Pte. Q.	..	22	4	$\frac{9}{1\frac{1}{2}}$	" "	9.7.04	11.8.04	Non-suppurating bubo, L. groin, on admission (hyperplastic mass). ( <i>Concealment</i> )	34	No induration of chancre; ingl. glands not indurated on subsidence of hyperplastic mass; single sore, roll of prepuce. No Hg. No sec. s.
147	" B.	..	24	3	$\frac{9}{1\frac{1}{2}}$	" "	9.7.04	14.7.04	.. ..	37	No induration of chancre; ingl. glands n. No Hg. No sec. s. Two small ulcers.
148	" W.	..	23	5	$\frac{9}{1\frac{1}{2}}$	" "	10.7.04	9.8.04	.. ..	31	No induration of chancre; ingl. glands n. Frænal ulcer. No Hg. No sec. s.
149	" F.	..	19	1	$\frac{4}{1\frac{1}{2}}$	<i>Syphilis</i> ..	12.7.04	..	.. ..	..	Connections, May 23 and June 8, 1904. He noticed ulcer about July 5, a pin-head sized ulcer which got bigger and harder; ad- mitted hospital July 12. Small indurated Hunterian chancre, roll of prepuce reverted, L. side; left ingl. glands discretely enlarged and "bullet," the size of hazel nuts; local treatment; rash not yet appeared, August 20.
150	" T.	..	25	6	$1\frac{5}{1\frac{1}{2}}$	Non-infecting chancre	30.6.04	14.7.04	.. ..	15	No induration of chancre; ingl. glands n.; three ulcers, roll of prepuce. No Hg. No sec. s.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service, years in Command	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
151	Pte. C. . .	24	6	1 <sup>9</sup> / <sub>12</sub>	<i>Syphilis</i> . .	14.7.04	..	(Concealment) . .	..	Connections, May 1 and June 8, 1904 ; noticed ulcer July 8, admitted hospital July 13 ; single chancre, roll of prepuce reverted, R. side ; Hunterian induration, later cartilaginous ; R. ingl. glands considerably and discretely enlarged and "bullet," L. normal. No Hg in primary stage. Roseolar rash, Aug. 14, slightly infiltrated type, and left ingl. adenitis now commencing. Hg inunctions, Aug. 18.
152	" M. . .	23	3	1 <sup>9</sup> / <sub>12</sub>	Non-infecting chancre	14.7.04	2.8.04	..	20	No induration of chancre ; ingl. glands n. ; frenal ulcer. No Hg.
153	" N. . .	28	9	<sup>9</sup> / <sub>12</sub>	" "	4.7.04	16.7.04	..	13	No induration of chancre ; ingl. glands n. ; single ulcer not raised on corona glandis, R. No Hg. No sec. s.
154	" D. . .	19	1	<sup>4</sup> / <sub>12</sub>	" "	17.7.04	19.8.04	..	34	No induration of chancre ; ingl. glands n. ; single fissured erosion, tip of prepuce, dorsal aspect. No Hg. No sec. s.
155	Lance-Corpl. S. . .	23	4	1 <sup>4</sup> / <sub>12</sub>	" "	17.7.04	2.8.04	..	17	No induration of chancre ; ingl. glands n. ; frenal ulcer size of threepenny piece. No Hg. No sec. s.
156	Dr. S. . .	25	2	<sup>7</sup> / <sub>12</sub>	" "	17.7.04	2.8.04	..	17	No induration of chancre on corona glandis L. ; L. ingl. glands "resiliently" enlarged. He states they were always so. No Hg. No sec. s.
157	Pte. M. . .	22	3	<sup>9</sup> / <sub>12</sub>	" "	17.7.04	18.8.04	..	33	"Inflammatory thickening" of chancre ; ingl. glands n. ; single ulcer, thickened base and edges on corona glandis, R. dorsal aspect. No Hg. No sec. s. ? Pseudo-chancere induré.

158	Gunner W.	..	27	6	$1\frac{6}{1\frac{1}{2}}$	<i>Syphilis</i>	..	17.7.04	..	..	..	..	Connections, June 7 and 14, 1904; he noticed skin rubbed off on July 14; an adherent scab formed over it; admitted hospital, July 17; single ulcer size of threepenny piece, indurated base and edges, and slightly raised, situated left central of external surface and dorsal aspect of tip of prepuce; L. ingl. glands discretely enlarged, indurated, size of hazelnuts. No Hg in primary stage. Small round papular rash, Aug. 3. Ung. Hg inunctions.
159	Pte. H.	..	24	5	$\frac{9}{1\frac{1}{2}}$	Non-infecting chancre		19.7.04	29.7.04	..	..	11	No induration of chancre; ingl. glands n. No Hg. Single ulcer; no sec. s.
160	" B.	..	22	2	$1\frac{9}{1\frac{1}{2}}$	" "		19.7.04	5.8.04	..	..	18	No induration of chancre; ingl. glands n.; frænal ulcer perforating. No Hg. No sec. s.
161	" R.	..	19	1	$\frac{5}{1\frac{1}{2}}$	" "		19.7.04	..	Suppurating bubo, R.; cut, Aug. 11	..	..	No induration of chancre; no "bullet" glands; frænal ulcer resolved, Aug. 10, 1904; in hospital, Aug. 20. No Hg. No sec. s.
162	" S.	..	26	9	$1\frac{6}{1\frac{1}{2}}$	" "		21.7.04	2.8.04	..	..	13	No induration of chancre; ingl. glands n.; two small ulcers, roll of prepuce. No Hg. No sec. s.
163	" D.	..	22	1	$\frac{8}{1\frac{1}{2}}$	" "		21.7.04	13.8.04	..	..	24	No induration of chancre; ingl. glands n.; three minute ulcers near frænum. No Hg. No sec. s.
164	" T.	..	24	5	$1\frac{7}{1\frac{1}{2}}$	" "		6.6.04	23.7.04	Gonorrhœa	..	48	No induration of chancre; "inflammatory thickening"; single sore, roll of prepuce. "Resiliently" enlarged ingl. glands. No Hg. No sec. s.
165	Gunner A.	..	22	3	$1\frac{3}{1\frac{1}{2}}$	" "		25.6.04	23.7.04	Suppurating bubo, R., on admission; cut. ( <i>Concealment</i> )	..	29	Constitutional syphilis previously. Case taken.
166	Pte. H.	..	24	5	$\frac{9}{1\frac{1}{2}}$	" "		22.7.04	..	Bubo, R., on admission, suppurated; cut, Aug. 2. ( <i>Concealment</i> )	..	..	No induration of chancre; no "bullet" glands; four trivial ulcers. No Hg. In Hospital, Aug. 20, 1904. No sec. s.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser- vice			Admitted into hospital	Discharged from hospital			
167	Pte. M. ..	21	1	$\frac{7}{12}$	<i>Syphilis</i> ..	16.6.04	29.7.04	<i>Concealed</i> ..	44	Connection, May 13; ulcer noticed, June 10, patient states (?); admitted hospital, June 16; large Hunterian indurated chancre, roll of prepuce reverted, R. side; R. ingl. glands discretely enlarged and tender on pressure, L. normal. No Hg in primary stage. Roseolar rash, July 10, non-infiltrated, four days' duration; fever. Ung. Hg, July 15. Case taken.
168	„ McM. ..	23	4	$\frac{9}{12}$	„ ..	8.7.04	11.8.04	Non-suppurating hyperplastic matting, L. ingl. glands, for which he reported sick	34	Connections, May 20 and June 11, 1904; admitted hospital, July 8; superficially ulcerating papule, size of three pins' heads, L. side of corona glandis; matting of L. ingl. glands, amygdaloid and indurated glands in it; this indurated papule ulcerated on July 24. No Hg in primary stage; ingl. glands subsiding; roseolar rash. Aug. 18, non-infiltrated type. Ung. Hg inunctions. Case taken.
169	„ R. ..	23	5	$1\frac{9}{12}$	„ ..	24.7.04	..	<i>Concealment</i> ..	..	Connections, May 1 and 21, 1904; ulcer noticed, he states, June 7; admitted hospital July 24 off "Medical Inspection," with large Hunterian indurated chancre L. side of roll of prepuce reverted; roseolar rash, non-infiltrated and weal-like type; symmetrical severe ingl. adenitis. No Hg. in primary stage. May 21 is the probable date of infection. Ung. Hg, July 24.

170	Pte. J.	..	..	19	1	$\frac{6}{1\frac{1}{2}}$	<i>Syphilis</i>	..	18.6.04	..	..	..	..	Connections, May 8 and June 1, 1904; he noticed ulcer June 15; admitted hospital, gonorrhoea and chancre, June 18; small indurated ulcer, roll of prepuce reverted, L. side; L. ingl. glands enlarged, "bullet" glands; a second small ulcer tip of prepuce, July 15. No Hg in primary stage. Roseolar rash, July 23, non-infiltrated weal-like type; symmetrical ingl. adenitis.
171	Pte. M.	..	..	25	7	$\frac{8}{1\frac{1}{2}}$	Non-infecting chancre	25.7.04	25.7.04	19.8.04	..	..	26	No induration of chancre; ingl. glands n.; frænal ulcer. No Hg.
172	Gunner C.	..	..	20	4	$1\frac{6}{1\frac{1}{2}}$	"	25.6.04	25.6.04	..	..	Suppurating bubo, L., on admission; cut. (Concealment)	..	No induration of chancre; no "bullet" glands; frænal ulcer nearly healed on admission. No Hg. In hospital, Aug. 20, 1904. No sec. s.
173	Pte. A.	..	..	25	5	$\frac{8}{1\frac{1}{2}}$	"	26.7.04	26.7.04	1.8.04	..	..	7	No induration of chancre; ingl. glands n; single minute ulcer. No Hg.
174	" L.	..	..	20	2	$1\frac{9}{1\frac{1}{2}}$	"	26.7.04	26.7.04	..	..	Suppurating bubo, R., on admission; cut Aug. 1, 1904. (Concealment)	..	No induration of chancre; no "bullet" glands; two small erosions roll of prepuce healed, Aug. 3, 1904. In hospital, Aug. 20, with bubo. No Hg.
175	" H.	..	..	22	2	$\frac{7}{1\frac{1}{2}}$	"	27.7.04	27.7.04	1.8.04	..	..	6	No induration of chancre; "resilient" enlargement of ingl. glands; two small abrasions. No Hg.
176	" B.	..	..	23	2	$\frac{8}{1\frac{1}{2}}$	"	28.7.04	28.7.04	..	..	Suppurating bubo, L., on admission; cut Aug. 12, 1904. (Concealment)	..	No induration of chancre; single ulcer on left side of frænum; no "bullet" glands. In hospital on Aug. 20, 1904.
177	" C.	..	..	22	3	$\frac{9}{1\frac{1}{2}}$	<i>Syphilis</i>	31.7.04	31.7.04	..	..	Non-suppurating, hyperplastic mass on admission L. ingl. glands; paraphimosis and inflammatory œdema; no phagedæna. (Concealment)	..	Connections, July 1 and 21, 1904. He noticed ulcer July 20. Admitted hospital, July 31. Large, fleshy, single, unhealthily granulating ulcer, but no phagedæna, situated centrally on roll of prepuce, reverted and to left - this later became indurated; L. ingl. glands, on "subsidence" of matting, on Aug. 18, 1904, were discretely enlarged and "bulletry." No Hg in primary stage. Small, round papular rash, Aug. 18, on flanks and abdomen. Case taken.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
178	Pte. A. ..	23	3	$9\frac{1}{2}$	Non-infecting chancre	31.7.04	11.8.04	.. .. .	12	No induration of chancre; ingl. glands n.; frænal ulcer. No Hg.
179	„ G. ..	22	3	$9\frac{1}{2}$	„ „	31.7.04	..	.. .. .	..	No induration of chancre; ingl. glands n.; six multiple small erosions. No Hg. In hospital, Aug. 20, 1904.
180	„ W. ..	$21\frac{4}{12}$	1	$8\frac{1}{2}$	„ „	1.8.04	..	.. .. .	..	No induration of chancre; “resilient,” discrete enlargement of L. ingl. glands—he states previously so. No Hg. In hospital, Aug. 20, 1904
181	Corpl. M... ..	29	9	$8\frac{1}{2}$	<i>Syphilis</i> ..	2.8.04	..	(Concealment) ..	..	Connection, May 7, 1904. He noticed an ulcer on free edge of prepuce on May 22; concealed; this healed by June 21; admitted hospital Aug. 2; staining profuse, and large flat papular syphilide; symmetrical ingl. adenitis; other glands n.; coryza, mucous patch mouth. Ung. Hg inunctions Aug. 3. Case taken.
182	Pte. S. ..	24	5	$11\frac{6}{12}$	„ ..	2.8.04	..	(Concealment) ..	..	Connection pay day, June 30, 1904; chancre concealed. On admission, Aug. 2, single raised ulcer indurated, Hunterian chancre to right side of frænum, size of small hazel nut, cartilaginous base and sides; R. ingl. glands discretely enlarged and “bul-lety”; the L. ingl. glands have later become enlarged and “bullety.” No Hg in primary stage; no rash to date, Aug. 20. Case taken.
183	„ E. ..	24	3	$11\frac{6}{12}$	Non-infecting chancre	2.8.04	..	Bubo R. on admission; suppurated; cut Aug. 7, 1904	..	No induration of chancre; no discrete “bul-lety” glands on subsidence of bubo; trivial erosion healed Aug. 10, 1904; in hospital Aug. 20.

184	Pte. H.	..	27	11	1 $\frac{4}{12}$	<i>Syphilis</i>	..	8.8.04	..	(Concealment) five weeks	..	Connection pay day, May 30, 1904, and on June 30. He falsely states that the ulcer appeared on Aug. 4; on admission to hospital Aug. 8, single large raised indurated Hunterian chancre with crateriform necrotic centre, but no phagedæna on R. side of roll of prepuce reverted; roseolar rash Aug. 8; L. ingl. glands on this date are discretely enlarged and "bullety." No Hg in primary stage. Ung. Hg inunctions. Case taken.
185	Sapper D.	..	21 $\frac{6}{12}$	2	2 $\frac{8}{12}$	"	..	30.7.04	..	Urethral discharge; urethral chancre; phimosis; necrosis and slight phagedæna. (Concealment)	..	Connections, May 30 and July 3, 1904. He noticed urethral discharge July 23, then urethral chancre, balanitis and phimosis. On admission to hospital, July 30, urethral chancre at meatus urinarius size of three-penny piece; on the frænum is a second raised ulcer the size of a lentil bean; both ingl. glands are discretely enlarged and "bullety"; small round papular rash Aug. 4, with precedent roseolar earlier. No Hg in primary stage. Case taken.
186	Gunner D.	..	24	1 $\frac{9}{12}$	1 $\frac{1}{12}$	"	..	26.7.04	..	Urethral chancre; balanitis; inflammatory phimosis; phagedæna	..	On admission, urethral discharge and urethral ulcer erosive, phagadæna extends $\frac{1}{8}$ in. up, urethra cupped; the ingl. glands on "both" sides are discretely enlarged and "bullety." No Hg. in primary stage. Case taken.
187	Pte. C.	..	21	2	2 $\frac{9}{12}$	Non-infecting chancre	..	18.7.04	..	Gonorrhœa; balanitis..	..	No induration of chancre; ingl. glands n.; three small erosions; infection July 12 ( <i>vide</i> 109). In hosp. Aug. 20, 1904.
188	" B.	..	28	7	1	"	..	10.8.04	..	..	..	No induration of chancre; ingl. glands n.; two small erosions roll of prepuce. No Hg. In hospital Aug. 20, 1904.
189	" D.	..	23	5	1 $\frac{10}{12}$	"	..	7.8.04	13.8.04	..	7	No induration of chancre; ingl. glands n. No Hg.
190	" S.	...	29	9	2 $\frac{8}{12}$	"	..	12.8.04	..	..	..	No induration of chancre; R. ingl. glands discretely but "resiliently" enlarged; frænal ulcer involving R. side of frænum. No Hg. In hospital August 20, 1904.

# APPENDIX I.—Continued.

No. of case	Rank and Name	COMPLETED YEARS OF		Service in Command, years	Disease	DATES		Complications	No. of days under treatment	Remarks
		Age	Ser-vice			Admitted into hospital	Discharged from hospital			
191	Pte. C. ..	29	4	1½	Non-infecting chancre	13.8.04	19.8.04	.. .. .	7	No induration of chancre; ingl. glands n.; trivial erosion, roll of prepuce. No Hg.
192	" F. ..	20	2	1½	" "	13.8.04	..	Non-suppurating bubo, R., on admission; hy-perplastic mass. ( <i>Con- cealment</i> )	..	No induration of chancre; no "bullet" or amygdaloid enlarged glands evident in the matting; two small erosions tip of prepuce. No Hg. In hospital, Aug. 20.
193	" V. ..	20	2	1½	" "	14.8.04	..	.. .. .	..	No induration of chancre; ingl. glands n.; single small chancrous erosion, roll of prepuce, near frænum. No Hg. In hospital, Aug. 20.
194	" B. ..	22	..	..	<i>Syphilis</i> ..	2.8.04	..	Congenital and "ringed" phimosis	..	Connections, June 30, July 11 and 18; on admission, Aug. 2, congenital ringed phimosis; on free edge of prepuce two ulcers, the larger on L. side of tip of prepuce is raised; the L. ingl. glands discretely enlarged and "bullet." The prepuce cannot be withdrawn owing to ringed phimosis. Case taken.
195	Driver L...	20	1	8½	Non-infecting chancre	14.8.04	..	.. .. .	..	No induration of chancre; ingl. glands n.; single fissured chancre, roll of prepuce; same place but fresh connection ( <i>vide</i> 123); In hospital, Aug. 20.
196	Pte. B. ..	22	4	8½	" "	24.7.04	19.8.04	.. .. .	27	No induration of chancre; ingl. glands n.; two small chancrous erosions in sulcus. No Hg.
197	" A. ..	20	3	1½	" "	15.8.04	..	.. .. .	..	No induration of chancre; ingl. glands n.; single chancrous erosion, roll of prepuce. No Hg. In hospital, Aug. 20.

198	Gunner B.	..	29	8	..	Non-infecting chancre	14.7.04	..	..	..	..	..	No induration of chancre; ingl. glands n.; two small ulcers. No Hg. In hospital, Aug. 20.
199	Pte. E.	..	20	..	..	„ „	17.8.04	..	Non-suppurating bubo, L., on admission; hy-perplastic mass. ( <i>Concealment</i> )				No induration of chancre; no discretely enlarged "bullet" glands in the mass. No Hg. In hospital, Aug. 20.
200	„ D.	..	..	..	..	<i>Syphilis</i>	Prison	..	(Concealment). Prisoner.				Connection between Dec. 14 to 25, 1903, Cyprus; ulcer appeared, reported Feb. 13, 1904, case treated in prison; ulcer on glans penis, scabbed over; scarcely appreciable if any induration in the ulcer, which is irritated and centrally situated on the glans penis; healed by April 11, with loss of substance; roseolar rash, March 26, non-infiltrated type, lasting 14 days; symmetrical "bullet" buboes, both ingl. chains. No Hg. in primary stage. Ung. Hg inunctions, March 26. Case taken.

## APPENDIX II.\*

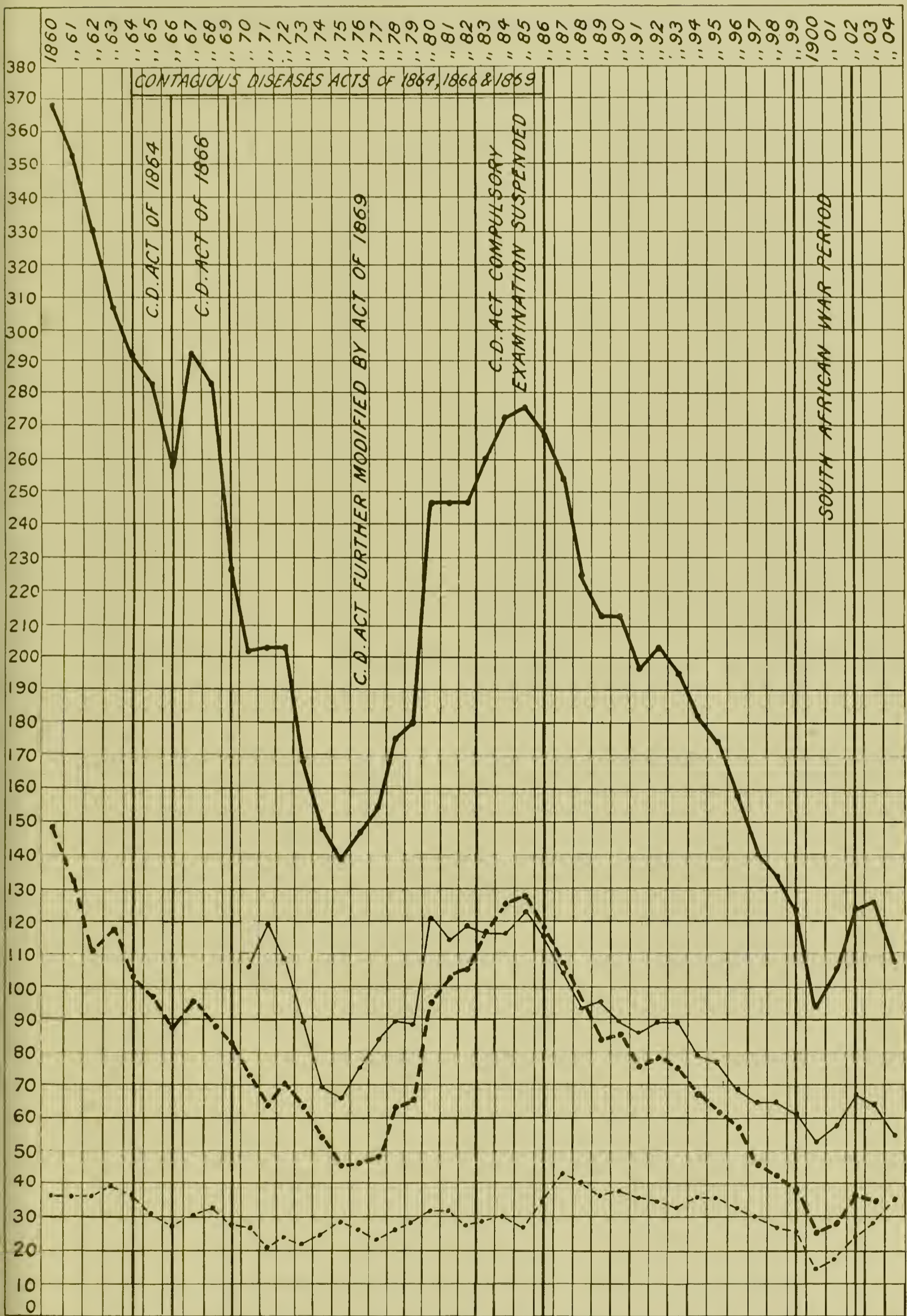
## RECRUITS.

Year	Number examined	Rejections, ratio per 1,000	Year	Number examined	Rejections, ratio per 1,000
1864	27,750	16·86	1884	66,882	10·57
1865	24,891	15·67	1885	72,249	9·77
1866	20,410	16·56	1886	74,991	8·18
1867	26,646	16·51	1887	60,976	8·08
1868	23,543	12·88	1888	49,172	7·73
1869	17,749	16·40	1889	53,904	6·64
1870	38,408	15·78	1890	55,967	6·29
1871	36,212	16·38	1891	61,322	4·88
1872	28,390	15·67	1892	68,761	4·61
1873	24,895	16·51	1893	64,110	4·87
1874	30,557	15·74	1894	68,761	5·67
1875	25,878	12·63	1895	55,698	3·48
1876	41,809	15·16	1896	54,574	3·67
1877	43,803	15·52	1897	59,986	3·47
1878	43,867	15·16	1898	66,502	3·85
1879	42,668	13·43	1899	68,087	2·61
1880	46,108	11·67	1900	84,402	2·21
1881	47,444	12·56	1901	76,750	2·22
1882	45,423	16·72	1902	87,609	2·49
1883	59,436	9·81	1903	69,553	2·79

\* Appendices II., III., IV, VII., VIII. are from Major McCulloch's article, *Royal Army Medical Corps Journal*, October, 1905.

VENEREAL DISEASES IN THE UNITED KINGDOM  
1860 - 1904.

CHART I.

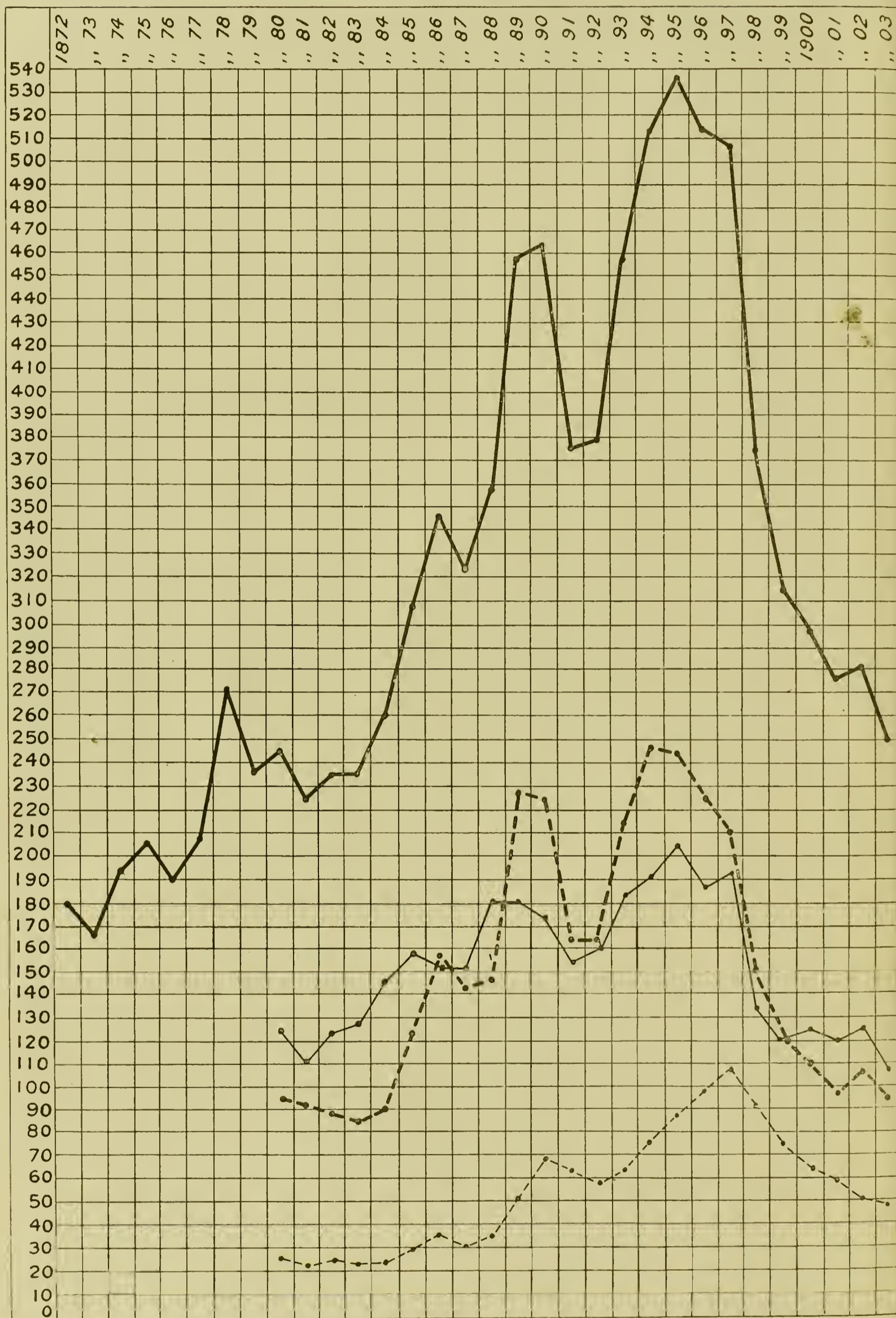


All venereal diseases ———  
Primary venereal sores - - - -

Secondary syphilis - - - - -  
Gonorrhoea ———

# VENEREAL DISEASES IN INDIA 1873 - 1903.

CHART II.

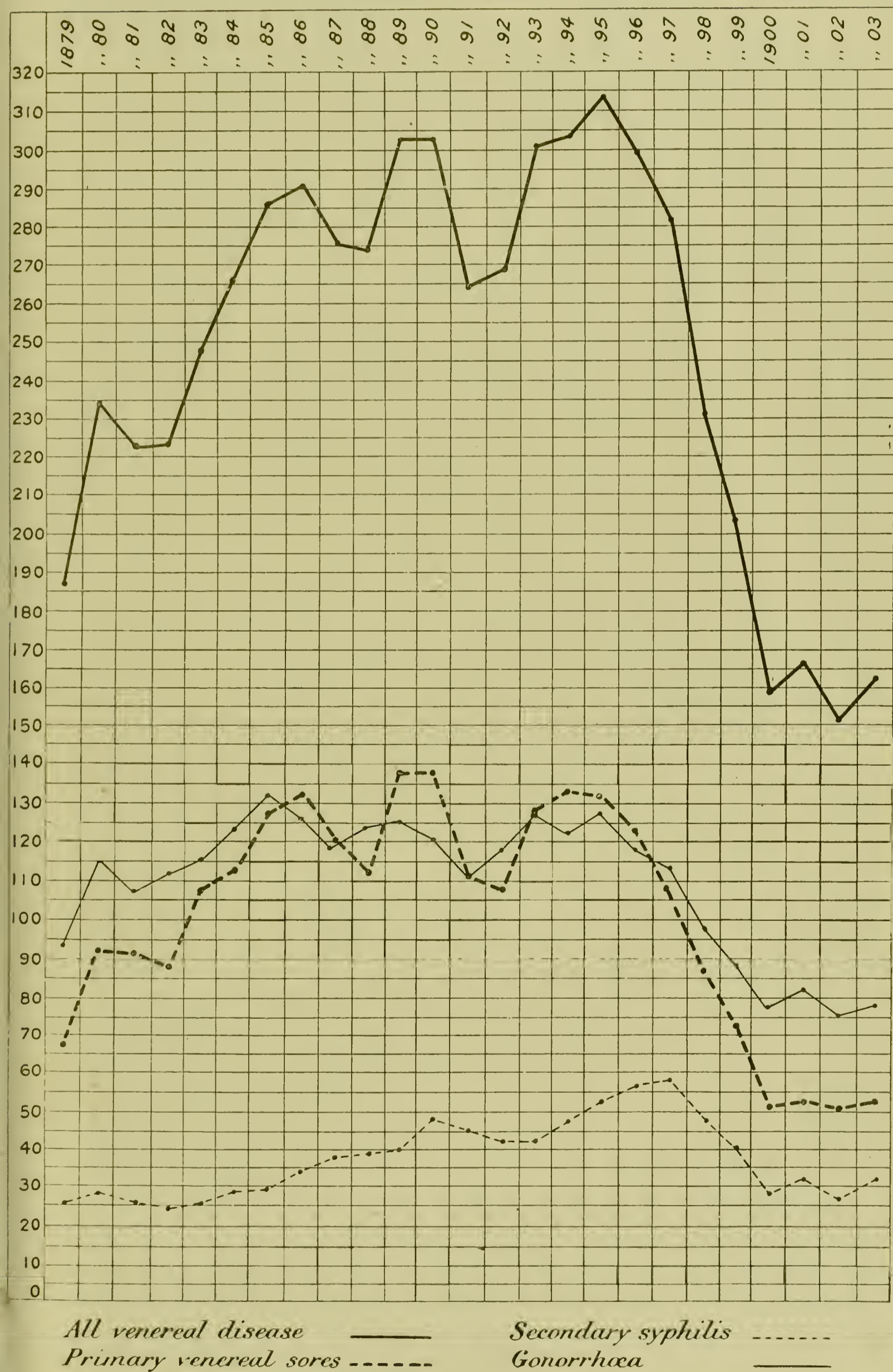


All venereal diseases ———  
Primary venereal sores - - - -

Secondary syphilis - - - -  
Gonorrhoea ———

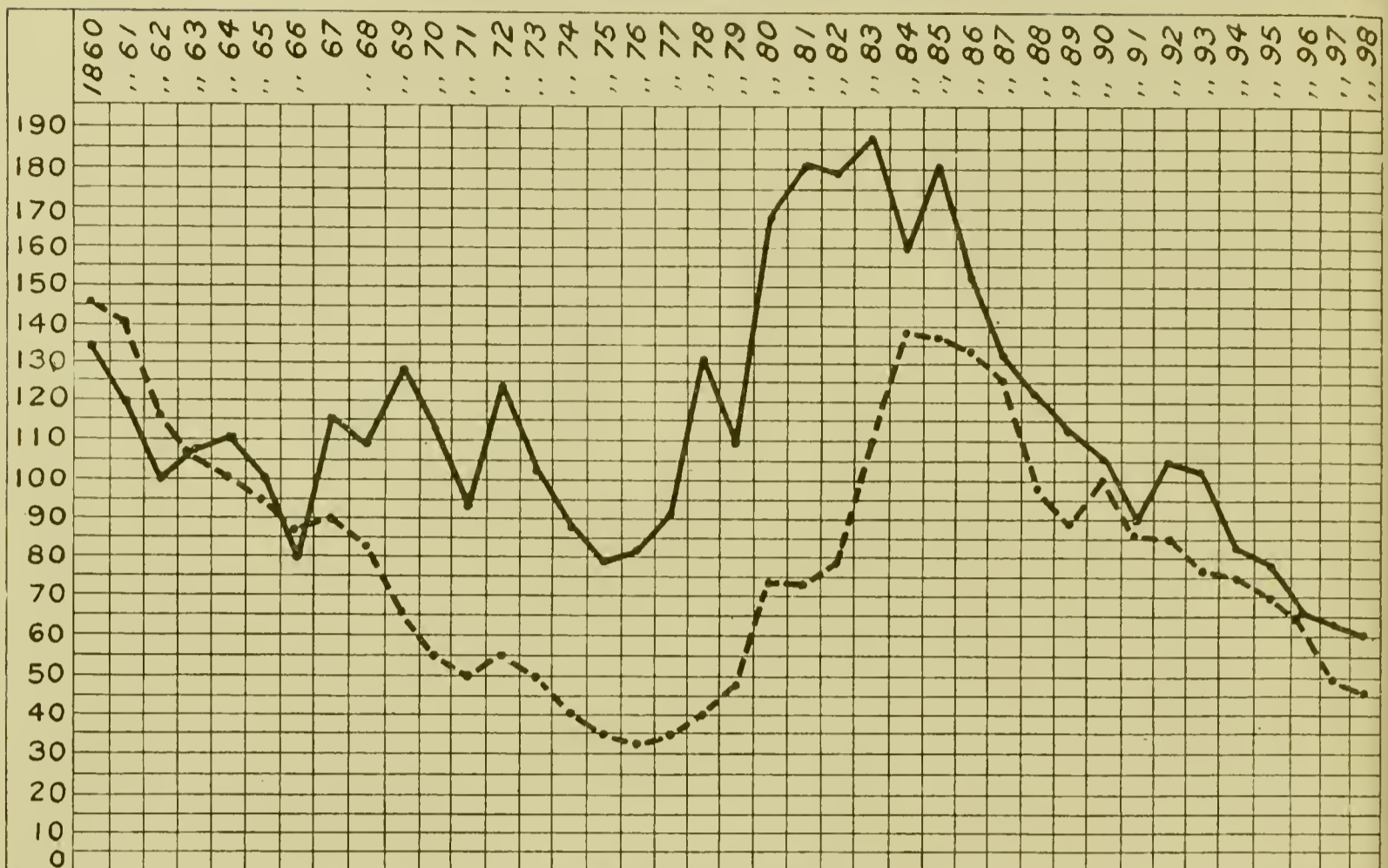
# BRITISH ARMY AT HOME AND ABROAD 1879-1903.

CHART III.



PRIMARY VENEREAL SORES

CHART IV.



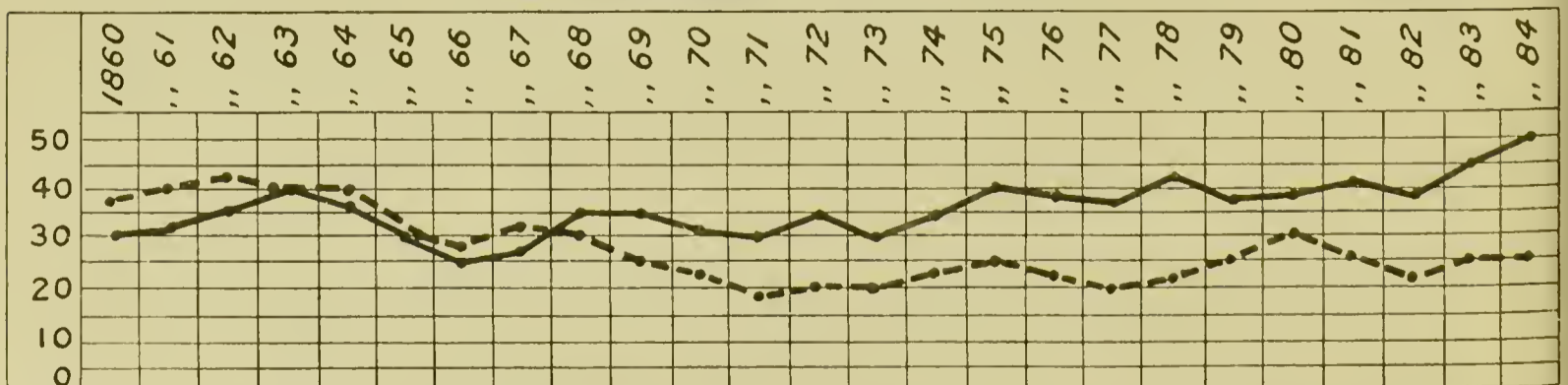
GONORRHOEA

CHART V.



SECONDARY SYPHILIS

CHART VI.



Fourteen large stations successively brought under the C.D.Acts. ---  
 " " " never brought under the Acts. ....

APPENDIX IV.

ADMISSIONS FOR SECONDARY SYPHILIS.

				Average annual ratio for the period	
1860-64—Before the Acts (five years)	..	..	..	36	per 1,000
1865-85—During the Acts (twenty-one years)	..	..	..	28	„
1886-99—After the Acts (fourteen years)	..	..	..	34	„
1900-01—War period (two years)	..	..	..	17	„

				Ratio per 1,000 for the year	
1902	..	..	..	23·8	
1903	..	..	..	28·6	

APPENDIX V.

TO SHOW THE GOOD EFFECT OF CONTROL UNDER CANTONMENT ACT, OCTOBER, 1897.  
(Refer also to Appendix XXII.)  
*Admission Ratio per 1,000 of Strength.*

INDIA.

Year		Primary venereal sore	Secondary syphilis	Gonorrhœa	Total
“Control” Cantonment Code	1895	245·5	86·8	204·6	536·9
	1896	226·5	97·7	187·4	511·6
	1897	210·9	106·2	190·7	507·8
	1898	148·7	88·2	134·4	371·4
	1899	120·5	71·9	121·1	313·5
	1900	109·6	62·5	125·9	298·0
	1901	97·7	58·3	120·0	276·0
	1902	107·0	49·9	124·5	281·4
	1903	95·8	46·7	107·0	249·5
	1904	—	—	—	200·3

APPENDIX VI.

CHANGE OF PERSONNEL, YOUTHFULNESS, RECENT ARRIVAL, AND MARRIAGE, IN RELATION TO VENEREAL DISEASE AND ENTERIC FEVER.  
*Long Service System, 1870-77, contrasted with Short Service, 1878-1900. Control in force 1870-84, 1887-88 and 1898-1900.*

Years	ARRIVED IN INDIA		Year	Percentage of strength				Strength	Ratio per 1,000			Ratio per cent. of total admission	
	Men	Women		Age	Length of residence	Married	Admissions			Venereal disease	Enteric fever		
							Under 25 years		Under 5 years			Enteric fever	
1870-71	8,805	826	1870	—	—	—	54,578	1,645·4	191·2	3·1	11·62	·19	
1871-72	9,134	920	1871	40	—	11·19	56,806	1,449·6	196·8	3·6	13·58	·25	
1872-73	8,271	809	1872	39	—	11·32	58,870	1,497·0	179·0	3·8	11·96	·25	
1873-74	8,680	816	1873	39	—	11·26	58,769	1,328·1	166·7	3·6	12·55	·27	
1874-75	7,840	673	1874	38	—	11·10	59,308	1,357·7	192·7	4·1	14·20	·30	
1875-76	7,568	752	1875	36	—	10·80	58,409	1,337·8	205·1	2·8	15·33	·21	
1876-77	8,170	591	1876	33	—	10·37	57,858	1,361·5	189·9	4·6	13·95	·34	
1877-78	9,113	482	1877	33	56	9·70	57,260	1,257·3	208·5	4·1	16·59	·32	
1878-79	13,113	575	1878	35	60	7·59	56,475	1,651·3	271·3	8·5	16·43	·51	
1879-80	13,142	612	1879	39	61	6·63	59,082	1,871·2	234·8	8·0	12·55	·43	
1880-81	13,165	664	1880	41	65	6·36	59,717	1,754·2	249·7	7·9	14·23	·45	
1881-82	9,895	349	1881	43	70	5·94	58,728	1,604·6	260·5	5·6	16·23	·35	
1882-83	9,748	325	1882	41	72	5·43	57,269	1,444·9	265·2	6·2	18·35	·43	
1883-84	12,525	433	1883	41	75	5·20	55,525	1,335·7	270·3	7·7	20·23	·58	
1884-85	11,822	393	1884	45	75	5·05	54,996	1,513·4	293·9	11·7	19·42	·77	
1885-86	17,766	508	1885	48	73	4·23	56,967	1,532·7	342·7	11·2	22·36	·73	
1886-87	11,645	372	1886	52	75	3·90	61,015	1,513·9	389·5	18·1	25·73	1·20	
1887-88	11,729	459	1887	52	73	3·84	63,515	1,369·7	361·2	12·7	36·37	·93	
1888-89	12,407	506	1888	50	76	3·65	68,887	1,381·7	370·6	13·6	26·82	·99	
1889-90	12,270	532	1889	49	78	3·60	69,266	1,498·0	481·5	22·9	32·14	1·53	
1890-91	14,046	542	1890	50	80	3·70	67,823	1,520·2	503·5	18·5	33·12	1·22	
1891-92	15,456	529	1891	51	79	3·36	67,030	1,379·1	400·7	20·4	29·06	1·48	
1892-93	15,894	540	1892	51	80	3·29	68,137	1,517·3	409·9	22·1	27·01	1·46	
1893-94	15,090	482	1893	53	79	3·29	70,091	1,414·9	466·0	20·0	32·94	1·41	
1894-95	15,957	517	1894	54	81	—	71,082	1,508·0	511·4	20·9	33·91	1·38	
1895-96	14,346	654	1895	55	83	—	71,031	1,461·8	522·3	26·3	35·73	1·80	
1896-97	14,805	545	1896	56	82	—	70,484	1,386·7	511·6	25·5	36·89	1·84	
1897-98	16,227	543	1897	55	84	—	68,395	1,556·9	485·7	32·4	31·20	2·08	
1898-99	16,911	648	1898	54	81	—	67,741	1,436·9	362·9	36·9	25·26	2·57	
1899-1900	3,369	168	1899	53	78	—	67,697	1,148·7	313·4	20·6	27·28	1·79	

## APPENDIX VII.

SHOWING THE ADMISSION RATIOS PER 1,000 OF AVERAGE STRENGTH AMONGST THE TROOPS SERVING ABROAD FOR THE DECENNIAL PERIOD 1893-1902, AND FOR THE YEAR 1903.

	ADMISSION RATIO FOR THE DECENNIAL PERIOD 1893-1902				ADMISSION RATIO FOR THE YEAR 1903			
	All venereal diseases	Primary venereal sores	Secondary syphilis	Gonorrhoea	All venereal diseases	Primary venereal sores	Secondary syphilis	Gonorrhoea
Hong Kong .. ..	441·8	174·3	69·5	198·0	355·7	109·8	23·8	222·1
Barbados .. ..	407·6	183·3	67·2	157·1	297·1	145·2	29·5	122·4
Straits Settlements ..	377·5	147·8	95·2	134·5	322·3	103·3	16·0	203·0
Egypt .. ..	281·2	134·8	40·3	106·1	283·4	115·2	20·6	147·6
Ceylon .. ..	234·2	87·0	38·1	109·1	235·3	75·0	14·0	146·3
Gibraltar .. ..	232·6	93·5	19·7	119·4	130·3	55·3	10·0	65·0
South Africa (1889-98)	211·7	73·6	45·3	92·8	71·4	23·2	16·1	32·1
Mauritius .. ..	219·7	78·5	31·3	109·9	343·2	164·9	59·0	119·3
Jamaica .. ..	216·5	80·3	41·4	94·8	219·9	70·9	23·1	125·9
Malta .. ..	134·6	39·7	15·5	79·4	105·7	20·9	16·6	68·2
Canada .. ..	124·8	30·6	16·3	77·9	61·4	5·5	10·6	45·3
Bermuda .. ..	39·5	9·1	10·5	19·9	33·4	5·9	12·4	15·1
United Kingdom ..	141·1	47·3	26·9	66·9	125·0	33·6	28·6	62·8
India .. ..	411·6	175·8	76·3	159·5	249·5	95·8	46·7	107·0

## APPENDIX VIII.

INVALIDING AND DEATHS FROM SYPHILIS, 1894-1903.

Invalided from abroad	INVALIDS DISCHARGED AS UNFIT FOR FURTHER MILITARY SERVICE			Deaths
	Of the invalids from abroad	From the home army	Total number discharged	
4,378	1,607	1,266	2,875	260
From India, 3,792	From India, 1,413			

## APPENDIX IX. (Contrast IX.A.)

## INVALIDS.

*Number of Soldiers Invalided from Abroad for Venereal Disease, received into the Royal Victoria Hospital, Netley.*

Year	Cases	Year	Cases
1880	86	1889	185
1881	65	1890	226
1882	55	1891	234
1883	69	1892	229
1884	46	1893	246
1885	79	1894	382
1886	66	1895	420
1887	93	1896	449
1888	137	1897	804

(*British Medical Journal*, 1899.)

*A voluntary system of control existed in India in the years 1889-1893. No control, 1894-1897.*

## APPENDIX IX.A. (Contrast IX.)

## INDIA.

*Invalids and Admissions. Ratio per 1,000. Venereal diseases.*

Year	Invaliding ratio per 1,000	Admission ratio per 1,000
1897	10·26	507·8
1898	8·70	371·4
1899	6·53	313·5
1900	6·24	298·0
1901	6·26	276·0
1902	5·12	281·4
1903	3·06	249·6
1904	2·83	200·3

(*British Medical Journal*, November, 1905—Lieut.-Col. Lambkin, R.A.M.C.)

The above shows marked “decrease” as a result of the control of prostitution in India (Cantonment Code, 1897), individual and systematised interest, and medical prophylaxis by treatment.—H. C. F.

## APPENDIX IX.B.

## BRITISH ARMY.

*Admissions, Deaths, Invalids, constantly Sick. Ratio per 1,000.**(Average Strength, 242,182.)*

Year	Disease	Admissions	Deaths	Invalids sent home	Invalids finally discharged	Constantly sick
Decennial average 1893 to 1902	Syphilis (primary)	57·50	—	0·04	—	5·43
	Syphilis (secondary)	43·60	0·12	4·52	1·30	4·70
	Totals ..	101·1	0·12	4·56	1·30	10·13
1903	Syphilis (primary)	21·0	—	0·02	—	2·12
	Syphilis (secondary)	31·3	0·07	1·91	0·82	3·62
	Totals ..	52·3	0·07	1·93	0·82	5·74

*(British Medical Journal, November, 1905—Lieut.-Col. Lambkin.)*

In the decennial average, 1893-1902, continuous treatment was not generally adopted.

In 1903 *systematic treatment* was universally adopted.

# APPENDIX X.

## INVALIDING.

Relation of Invaliding to Age and Length of Residence in India, 1899.\*

A.—AGE												B.—LENGTH OF RESIDENCE IN INDIA														
Causes of invaliding	(a) Invalided per 1,000						(b) Liability in percentages						(c) Invalided per 1,000						(d) Length of residence in India							
	Under 20	20 and less than 25	25 and less than 30	30 and less than 35	35 and less than 40	40 & upwards	Under 20	20 and less than 25	25 and less than 30	30 and less than 35	35 and less than 40	40 & upwards	Under 1	1 and less than 1	2 and less than 3	3 and less than 4	4 and less than 5	5 and less than 10	10 & upwards	Under 1	1 and less than 2	2 and less than 3	3 and less than 4	4 and less than 5	5 and less than 10	10 & upwards
	51	8.44	5.80	3.64	1.33	2.16	2	39	27	17	6	10	3.57	8.04	7.73	7.70	7.85	6.76	1.80	8	19	18	18	18	16	4
Venereal diseases	(c) No. invalided						(d) Composition of 100 invalidings at each age						(e) No. invalided						(f) Composition of 100 invalidings in each period of residence							
	1	278	143	17	2	1	5	22	21	15	4	4	43	98	83	73	64	77	4	12	20	22	27	25	22	7
Venereal diseases	(e) No. invalided						(f) Percentage at each age to total No.						(g) No. invalided						(h) Percentage in each period of residence to total No.							
	1	278	143	17	2	1	0	63	32	4	0	0	43	98	83	73	64	77	4	10	22	19	17	14	17	1

\* Sanitary Report of Commissioners with the Government of India, 1899.

APPENDIX XI.

ADEN.\*

BRITISH TROOPS.

*To show good Effect of Control in a Station known to the Writer in 1896-97.  
Control commenced in 1898.*

Year	Average strength	Primary syphilis	Soft chancre	Secondary syphilis	Gonorrhoea	Total venereal disease	Total venereal disease. Admission ratio per 1,000
1896	1,026	64	93	103	156	416	405·5
1897	1,068	114	109	88	160	471	441·0
Con- { 1898	1,014	14	54	86	92	246	242·6
trol { 1899	1,095	13	24	44	63	144	131·5

\* Compiled by writer.

APPENDIX XII \*

MHow (Central India).

To SHOW THE EFFECT OF CONTROL IN STATION KNOWN TO WRITER, 1898-1900.

Venereal ratios to be read in conjunction with Appendix XII.A. (which shows the relationship with Enteric Fever).

The figures in Appendix XII. are gross totals.

MHow		ADMISSIONS					INVALIDING			NUMBER OF CONSTANTLY SICK				Remarks	
Year	Strength	Primary syphilis	Secondary syphilis	Gonor- rhea	Soft chancre	Total	Primary syphilis	Secondary syphilis	Gonor- rhea	Total	Primary syphilis	Secondary syphilis	Gonor- rhea		
1886 .. 1887 (Mar.) 1888 .. (1) C.D. Act	1,324	335	97	221	109	762	—	3	1	4	29·88	9·12	16·27	The incidence of “freshly contracted” disease in 1887 is identical with the year 1899, but 200 less in strength. Control in force in both years.	
	1,478	124	37	144	43	348	—	3	—	3	12·43	9·74	4·32		
	1,461	55	31	391	12	489	—	1	—	1	5·18	3·17	27·67		
1889 .. 1890 .. 1891 .. 1892 .. 1893 .. (2) Voluntary System	1,670	274	34	306	66	680	—	1	1	2	22·48	3·63	21·15		
	1,496	236	78	331	101	746	—	—	—	5	2·01	5·50	17·16		
	1,653	47	59	346	144	596	—	—	—	1	4·97	8·29	26·11		
	1,583	62	66	311	195	634	—	—	—	7	5·94	8·39	23·70		
	1,589	70	75	441	357	943	—	8	—	8	6·75	8·88	35·48		
1894 .. 1895 .. 1896 .. 1897 .. (3) No Control	1,642	409	131	497	323	1,360	—	6	1	7	36·89	14·97	37·39		Increase in 1894 directly due to the cessation of control in 1893. Ditto. Ditto.
	1,799	454	156	443	212	1,265	—	6	1	7	43·58	15·47	32·21		
	1,782	451	189	310	110	1,060	—	15	—	15	45·17	24·10	26·47		
	1,652	163	228	290	122	803	—	32	—	32	17·66	29·74	26·81		
1898 (Aug.) 1899 .. (4) Can- tonment Code	1,665	166	235	218	116	735	1	17	1	19	17·73	24·79	18·91		
	1,672	33	143	146	130	452	—	23	—	23	3·65	17·98	13·43		

1886.—Lock Hospital was closed.  
1887-88.—Lock Hospital system was in force.  
1889-93.—Voluntary attendance of women.

\* Compiled by writer.

## APPENDIX XII.A.\*

## ENTERIC FEVER RATIOS AT MHOW IN RELATION TO VENEREAL DISEASE.

To be read in conjunction with Appendix XII.

MHOW		ADMISSIONS			
Year	Strength	Enteric	Continued fever	Paroxysmal	Total admissions from all causes
1886	1,324	11	33	577	2,281
1887	1,478	56	76	537	1,557
1888	1,461	10	24	758	2,115
1889	1,670	118†	75	956	2,802
1890	1,496	24	30	736	2,559
1891	1,653	33	10	541	2,061
1892	1,583	22	14	626	2,246
1893	1,589	10	5	505	2,095
1894	1,642	110‡	18	548	2,911
1895	1,799	32	8	474	2,723
1896	1,782	79	22	553	2,764
1897	1,652	81	86	625	2,678
1898	1,665	76	82	960	3,018
1899	1,672	49§	28	524	2,113

\* Compiled by writer.

† Purely local cause: a new reservoir made with foul soil from Baircha village.

‡ Sudden rise in enteric fever in 1894. No C.D. Act in force. Note enormous increase of venereal disease in 1894 in Appendix XII.

§ Note also continued decrease of venereal disease in Appendix XII. and of admissions from all causes.

|| Control in force.

1886.—Lock Hospital was closed.

1887-88.—Lock Hospital system in force.

1889-93.—Voluntary attendance of women.

1894-97.—No C.D. Act, or control.

1898-99.—New Cantonment Code. (Control.)

This appendix can also be contrasted with Appendix VI. as regards relationship between venereal disease and enteric fever. It can be noted in Appendix VI. that whilst control was in force in the years 1870-84, 1887-88, and in 1899, both venereal disease and enteric fever were less.

## APPENDIX XIII.\*

NAGPUR DISTRICT (Kamptee), 1900.

BRITISH TROOPS.

*Admissions by Months. Average Annual Strength, 1,042.*

To show *seasonal* prevalence and incidence of freshly contracted disease in station known to writer. April to June = Hot weather.

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
Primary syphilis..	1	8	11	1	1	1	1	1	2	--	2	2	31
Soft chancre ..	4	8	15	4	4	4	7	3	5	11	21	14	100
Secondary syphilis	5	6	3	7	4	2	4	6	3	4	3	5	52
Gonorrhœa ..	22	11	14	6	7	8	13	15	25	17	8	12	158
Total venereal diseases	32	33	43	18	16	15	25	25	35	32	34	33	341

\* Compiled by writer.

## APPENDIX XIV.\*

KAMPTÉE (Nagpur District), 1901.

BRITISH TROOPS.

*Admissions by Months for Venereal Diseases. Average Strength, 885.*

To show *seasonal* incidence of freshly contracted disease in station known to writer. April to June = Hot weather.

Disease	Jan.	Feb.	March	April	May	June	Total
Primary syphilis..	—	1	—	—	—	1	2
Soft chancre ..	13	7	5	7	6	1	39
Secondary syphilis	3	1	3	4	1	—	12
Gonorrhœa ..	8	10	11	12	14	7	62
Total .. ..	24	19	19	23	21	9	115

\* Compiled by writer.

## APPENDIX XV.\*

KAMPTEE (India).

VENEREAL DISEASES.

(Station known to Writer, 1900-1.)

Year		Average strength	Primary syphilis	Secondary syphilis	Gonorrhœa	Soft chancre	Total venereal disease	Percentage of total venereal disease	Percentage of secondary syphilis
	1884 ..	770	23	13	108	—	144	18·70	1·69
	1885 ..	978	28	4	162	—	194	19·84	0·40
	1886 ..	838	4	6	68	189 (ulcer of penis)	267	31·86	0·72
(1) C.D. Act	1887 ..	879	6	7	142	284	429	49·94	0·79
	1888 ..	788	25	22	132	151	330	42·39	2·79
(2) Voluntary examina- tion of women	1889 ..	967	146	60	175	116	497	51·40	6·20
	1890 ..	910	407	85	192	—	604	66·37	9·34
	1891 ..	889	172	52	168	—	392	44·09	5·85
	1892 ..	875	99	96	205	84	484	55·32	10·97
	1893 ..	906	282	62	249	25	618	68·21	6·85
(3) No control	1894 ..	776	130	27	154	—	311	40·08	3·48
	1895 ..	929	64	35	166	193	458	48·23	3·77
	1896 ..	995	18	45	190	306	559	56·19	5·00
	1897 ..	866	37	68	260	255	620	71·59	7·85
(4) Control	1898 (Sept.)	762	30	65	100	83	278	36·48	8·53
	1899 ..	1,057	33	58	134	99	324	30·65	5·49
	1900 ..	1,042	31	52	158	100	341	32·73	4·99

\* Compiled by writer.

*Note 1.*—Primary syphilis, soft chancre and gonorrhœa are markedly reduced by the control of 1898-1900.

*Note 2.*—Secondary syphilis is commonly old-standing disease. It is only decreased in a marked degree after the control has been in force some time.

*Note 3.*—The benefit of control must be looked for in reducing sores and gonorrhœa, that is, in the Total Venereal Disease column.

*Note 4.*—In those years where “soft chancre” is left blank all soft chancres have been returned under primary syphilis for statistical reasons only.

*Note 5.*—1884 was the last year in which the full control of the Lock Hospital system was exercised.—H. C. F.

## APPENDIX XVI.

## RELATIVE PREVALENCE OF VENEREAL AND OTHER DISEASE IN INDIA, 1896.

Stations (Strength over 1,000)		ADMITTED PER 1,000		DIED PER 1,000	
		Ague	Venercal disease	Enteric fever	Hepatitis and abscess of liver
Rangoon	1886-90	225·2	492·6	2·66	3·10
	1891-95	184·4	543·6	2·45	2·65
Fort Dufferin	1888-90	607·5	703·4	2·24	3·58
	1891-95	478·5	560·1	2·59	1·08
Fort William	1886-90	257·9	564·0	2·26	2·26
	1891-95	258·5	602·3	2·00	·91
Fyzabad ..	1886-90	177·5	471·8	4·48	1·89
	1891-95	194·5	576·1	3·65	1·46
Lucknow	1886-90	132·6	418·7	5·76	1·42
	1891-95	135·5	527·0	8·41	1·70
Allahabad	1886-90	412·7	600·2	6·55	2·87
	1891-95	310·5	651·0	3·51	1·24
Bareilly ..	1886-90	192·9	505·4	11·73	1·42
	1891-95	107·5	693·3	7·33	1·11
Meerut ..	1886-90	530·1	509·0	5·59	1·00
	1891-95	474·4	456·6	10·12	·92
Umballa..	1886-90	199·9	323·4	2·74	1·52
	1891-95	247·2	407·7	8·11	·72
Ferozepore	1886-90	359·0	394·0	4·85	·61
	1891-95	929·3	345·2	5·00	·77
Sialkot ..	1886-90	273·5	411·8	11·65	·86
	1891-95	598·8	423·8	6·24	·16
Rawalpindi	1886-90	412·9	449·9	5·19	1·08
	1891-95	363·0	449·6	8·39	1·01
Peshawar	1886-90	641·2	380·4	5·74	·85
	1891-95	983·7	239·7	10·09	·97
Mooltan ..	1886-90	238·4	530·5	4·25	·95
	1891-95	571·2	460·3	4·11	·46
Kurrachee	1886-90	327·6	259·6	4·91	1·71
	1891-95	924·9	327·2	1·65	·83
Agra ..	1886-90	294·9	499·4	7·29	·59
	1891-95	174·3	522·3	7·99	1·87
Mhow ..	1886-90	492·4	419·1	7·75	·55
	1891-95	310·8	580·4	5·93	·97
Poona ..	1886-90	227·8	398·0	3·26	·41
	1891-95	321·9	545·5	6·81	1·18
Belgaum..	1886-90	72·5	485·5	·61	1·42
	1891-95	69·6	545·2	·38	·94
Secunderabad	1886-90	43·8	387·9	7·53	1·68
	1891-95	111·0	470·8	4·62	·70
Colaba ..	1886-90	233·2	444·9	1·43	·95
	1891-95	214·7	519·3	2·11	1·76
Bangalore	1886-90	26·2	338·9	4·04	1·04
	1891-95	51·8	444·0	2·93	·78
Ranikhet	1886-90	78·1	441·1	7·26	2·13
	1891-95	80·6	636·1	3·73	1·04
Quetta ..	1886-90	526·5	203·7	3·53	1·31
	1891-95	759·6	308·0	2·81	1·00
Wellington	1886-90	170·0	472·2	2·09	2·87
	1891-95	98·5	394·6	2·73	·39
Aden ..	1886-90	191·3	227·0	1·96	1·71
	1891-95	819·0	306·7	1·69	1·06

## APPENDIX XVII.

## BRITISH TROOPS.

*Admission rate per 1,000 for venereal disease as far back as the records for India as a whole permit. The heading "Primary Syphilis" includes soft chancre throughout. The statistics of "Gonorrhœa" are also included in "Total Venereal Diseases."*

Year	Primary syphilis	Secondary syphilis	Total venereal diseases	
Control	1872	61·2	22·4	179·0
	1873	53·4	20·4	166·7
	1874	68·3	25·2	192·7
	1875	67·1	25·1	205·1
	1876	59·8	23·9	189·9
	1877	65·2	22·1	208·5
	1878	95·3	22·0	271·3
	1879	79·2	24·5	234·8
	1880	87·9	23·1	249·7
	1881	92·0	23·1	260·5
	1882	87·6	23·2	265·2
	1883	87·2	23·5	270·3
	1884	90·2	24·4	293·9
Control	1885	122·1	28·7	342·7
	1886	157·9	33·3	389·5
	1887	142·1	29·4	361·2
	1888	142·1	32·4	370·6
	1889	225·1	51·2	481·5
	1890	220·7	66·3	503·5
	1891	159·2	60·0	400·7
	1892	161·1	57·8	409·9
	1893	213·6	61·6	466·0
	1894	248·1	74·6	511·4
	1895	239·0	84·9	522·3
	1896	226·4	97·7	511·6
	1897	201·7	101·9	485·7
Control	1898	145·0	87·1	362·9
	1899	120·5	71·9	313·4
	1900	..	..	298·0
	1901	..	..	276·0
	1902	..	..	281·4
	1903	..	..	249·5
	1904	..	..	200·3

*Note 1.*—The increasing incidence since 1878 amongst British troops appears due to batches of young unmarried men under the Short Service System.

*Note 2.*—Control appears to markedly reduce secondary (constitutional) syphilis. Contrast the years 1887-8 (control in force) with the years 1889 to 1897 inclusive (no control). Also 1898-1904 (control). It is regretted that the figures for primary and secondary syphilis, 1900 to 1904, have not been obtained.—H. C. F.

APPENDIX XVIII.

NATIVE TROOPS.

The following table is given to compare with the corresponding one in Appendix XVII.

Year	Primary syphilis	Secondary syphilis	Total venereal diseases	
Control {	1877	11.5	5.3	26.7
	1878	16.3	5.8	37.5
	1879	16.5	7.0	37.1
	1880	15.0	5.8	33.3
	1881	17.9	7.2	39.5
	1882	14.7	5.9	34.4
	1883	13.0	6.5	31.6
	1884	11.0	5.3	27.9
	1885	11.2	5.9	30.1
	1886	13.7	6.0	28.1
Control {	1887	12.6	6.1	27.4
	1888	13.5	5.4	31.5
	1889	16.6	6.4	38.9
	1890	16.0	6.9	41.1
	1891	13.6	6.9	37.9
	1892	14.1	7.9	39.6
	1893	13.3	9.0	36.4
	1894	13.8	8.2	32.3
	1895	13.1	7.3	31.3
	1896	15.5	8.9	37.2
Control {	1897	16.1	9.0	40.8
	1898	14.3	11.5	40.0
	1899	11.3	9.9	34.1

Incidence is fairly constant in case of Native troops, but the amount of disease is much less than in the case of British troops. "Total Venereal Diseases" are slightly higher in 1889 to 1897 when *no control* existed. —H. C. F.

## APPENDIX XIX.

DEESA.\*

ADMISSIONS, VENEREAL DISEASES.

*British and Native Troops.*

January, February and March, 1899.

	Strength of troops	JANUARY				FEBRUARY				MARCH				Number of women examined	Number of women diseased
		Secondary syphilis	Primary syphilis	Gonorrhœa	Soft chancre	Secondary syphilis	Primary syphilis	Gonorrhœa	Soft chancre	Secondary syphilis	Primary syphilis	Gonorrhœa	Soft chancre		
British troops ..	300	2	1	6	2	1	4	2	3	3	1	5	2	(Jan.) 7	2
13th Bombay Inf. (native troops)	604	2	1	..	1	2	..	1	..	2	..	..	1	(Feb.) 1	..
2nd Bombay Lans. (native troops)	363	..	1	1	4	..	..	..	..	..	1	1	..	(Mar.) 2	2
Total .. ..	1,267	4	3	7	7	3	4	3	3	5	2	6	3	10	4
	1,267	21				13				16					

\* Compiled by writer in a station known to him.

## APPENDIX XX.

DEESA.\*

ADMISSIONS, VENEREAL DISEASES.

*British and Native Troops.*

April, May and June, 1899.

	Average strength of troops	APRIL				MAY				JUNE				Number of women examined	Number of women diseased
		Soft chancre	Gonorrhœa	Primary syphilis	Secondary syphilis	Soft chancre	Gonorrhœa	Primary syphilis	Secondary syphilis	Soft chancre	Gonorrhœa	Primary syphilis	Secondary syphilis		
British troops	283	3	2	..	3	..	1	..	2	1	2	..	2	(Apl.) 13	7 { 3 Gonorrhœa 1 Soft chancre 1 Pr. syphilis 2 Sec. „
13th Bombay Infantry	598	..	1	..	..	..	..	1	..	..	..	..	..	(May) 0	
2nd Bombay Lancers	337	1	..	..	..	..	..	..	..	..	..	..	..	(June) 5	
Total ..	1,218	4	3	..	3	0	1	1	2	1	2	..	2	18	12
	1,218	10				4				5					

\* Compiled by writer in a station known to him.

APPENDIX XXI. (Refer to Appendices XIX., XX.)

DEESA.\*

BRITISH TROOPS.

*Admissions for Venereal Disease.*

Cantonment Code Control commenced in August, 1898.

	Year	Average strength	Primary syphilis	Soft chancre	Secondary syphilis	Gonorrhœa	Total	Total venereal diseases. Admissions ratio per 1,000
Control	1896	302	17	27	31	105	180	596
	1897	339	25	47	31	89	192	566·4
	1898	299	8	45	15	45	113	377·9
	1899	264	9	19	29	30	87	329·5

\* Compiled by writer.

APPENDIX XXII.

CANTONMENT CODE. INDIA, 1899.\*

The paragraphs relating to Sanitary prophylaxis should, I think, be more simply and clearly arranged than at present.

The following order is suggested—paragraphs to be re-numbered in *sequence* :—

- Para. 175. Public prostitutes not to reside in *Regimental Bazaar*.  
,, 209. Loitering and importuning.  
,, 174. Prohibition of  
    (a) Brothels;  
    (b) Prostitutes.  
,, 86. Lamps in streets.  
,, 87. Names on streets. Numbers on houses.  
,, 196. Provision of *several free* Dispensaries.  
,, 201. Cantonment authority can authorise admission of any class of case into Dispensaries.  
,, 203. Issue of notice by Medical Officer on "*prima facie*" evidence.  
,, 204. Refusal to obey notice.  
,, 177. Notification of infectious or contagious disease by Medical practitioners. Private persons.  
,, 105. Notification of disease by Inn-keepers.  
,, 207. Routes for pilgrims, famine cases, &c.  
,, 178. Authority to G. O. C. for extra measures in emergencies.  
,, 208. Prohibition of begging.  
,, 210. Removal of disorderly persons.  
,, 211. Authority to G. O. C. to remove any person.  
,, 212. Harboursing evicted persons.  
,, 204. (2) Return of evicted persons.

\* Compiled by writer.

APPENDIX XXIII. (*Vide* Appendix XXXV., p. 114).

## AMENDED SYPHILIS CASE SHEET, A. F., 1238.\*

Serial number in register \_\_\_\_\_ Station \_\_\_\_\_

Regtl. No. \_\_\_\_\_ Rank and name } \_\_\_\_\_ Corps \_\_\_\_\_

(1) Probable date and place of infection \_\_\_\_\_

(2) Date of appearance of sore \_\_\_\_\_

(3) Character of sore \_\_\_\_\_

(4) Treatment (if any) before being placed on the Syphilis Register. \_\_\_\_\_

(5) Date of being placed on the Syphilis Register \_\_\_\_\_

(6) Condition at that time as regards—Weight \_\_\_\_\_

Urine

Skin

Mucous membranes

Lymphatic glands

Other symptoms \_\_\_\_\_

*Signed here.*

Treatment and progress. (The weight should be noted at regular intervals, any constant decrease being an indication to suspend treatment. Changes of stations, re-admissions to hospital, and alterations of treatment, with dates, should be noted. The dates and doses of mercurial injections should be given.)

Date	Weight	Urine	Treatment	Progress	Remarks and initials

\* Suggested by writer.—H. C. F.

# APPENDIX XXIV.

## SYPHILIS ATTENDANCE ROLLS FOR OUT-PATIENTS.\*

Chronic intermittent treatment (*i.e.*, six weekly injections of gr. i. Hg. Grey oil—rest for two months—then six more injections, and so on, for two years.

The *Monthly* roll is for those Men at large Stations who are resting between courses, and who have previously undergone six to nine months' thorough treatment, or inspection, on the weekly roll. A man can also be transferred from the monthly to the weekly roll as occasion requires. This scheme, at large stations, works well with Commanding officers and the men, and fulfils all ordinary requirements.

### WEEKLY INJECTIONS AND INSPECTIONS.

Corps	Rank	Name	DATES OF ATTENDANCE						Remarks
			1	2	3	4	5	6	
Suf. ..	Private	K.	12.10.05	19.10.05	26.10.05	3.11.05	7.11.05	14.11.05	Completed course. Transferred to Monthly Roll.
R.H.A. ..	Driver	G.	10.10.05	17.10.05	24.10.05	31.10.05	"	"	"
Suf. ..	Private	B.	3.10.05	"	"	"	"	"	"
R.H.A. ..	Driver	S.	10.10.05	"	"	"	"	"	"
R.E. ..	Sapper	L.	24.10.05	31.10.05	7.11.05	14.11.05	21.11.05	28.11.05	"
R.H.A. ..	Sergeant	P.	"	"	"	"	"	"	"
R.F.A. ..	Bombardier	McL.	31.10.05	7.11.05	14.11.05	21.11.05	28.11.05	"	"
" ..	Staff-Sergeant	P.	14.11.05	21.11.05	28.11.05	"	"	"	Furlough from Oct. 31 to Nov. 30.
" ..	Gunner	K.	"	"	"	"	"	"	"
R.H.A. ..	Bombardier	P.	"	28.11.05	"	"	"	"	"
R.A.M.C. ..	Private	F.	"	21.11.05	28.11.05	"	"	"	"
R.F.A. ..	Driver	K.	"	"	"	"	"	"	"
" ..	"	C.	21.11.05	28.11.05	"	"	"	"	"
" ..	"	R.	14.11.05	21.11.05	28.11.05	"	"	"	"
A.O.C. ..	Private	E.	"	"	"	"	"	"	"
Suf. ..	"	M.	28.11.05	"	"	"	"	"	"
" ..	"	P.	"	"	"	"	"	"	"
R.F.A. ..	Gunner	H.	"	"	"	"	"	"	"
R.H.A. ..	Corporal	T.	"	"	"	"	"	"	"

\* Compiled by writer.

# APPENDIX XXIV.—Continued.

## *Syphilis Attendance.* MONTHLY INSPECTION.

Corps	Rank	Name	Date of last injection	Dates of attendance				Remarks
R.F.A. ..	Staff-Sergt.	G.	Refuses injections 15.8.05					
"	Gunner	C.	"					
R.A.M.C.	Private	B.	28.8.05					
R.F.A. ..	Gunner	P.	28.7.05					
"	"	M. C.	29.8.05					
R.H.A. ..	Trooper	A.	12.9.05					
"	Gunner	W.	"					
"	Bombardier	M.	7.11.05					
Suf. ..	Corporal	L.	26.9.05					
R.F.A. ..	Gunner	M.	19.9.05					
"	Driver	N.	14.11.05					
"	Private	K.	"					
R.H.A. ..	Driver	G.	"					
Suf. ..	Private	B.	"					
R.H.A. ..	Driver	S.	"					
R.E.R.A.	Gunner	C.	Refuses injections 5.9.05 3.10.05 17.10.05					
R.A.R.D.S.	Driver	P.	"					
A.S.C. ..	"	B.	7.11.05					
R.H.A. ..	"	B.	21.10.05					
5th R. Bat.	Rifleman	M.	17.11.05					
A.S.C. ..	Driver	T.	"					
"	"	S.	"					
K.R.R. ..	Sergeant	G.	"					
A.S.C. ..	Driver	R.	"					
								Died, pneumonia, Nov. 14.

## APPENDIX XXV.

## ARMY OF INDIA.\*

*British Troops.**Venereal Admissions of 1884, 1892 and 1893 compared.*

The year 1884 was the last in which the Contagious Diseases Acts were in full force in India. The following table compares the Venereal Statistics of 1884, 1892 and 1893:—

	1884		1892		1893	
	Strength, 55,349		Strength, 68,138		Strength, 70,091	
	Admis- sions into hospital	Ratio per 1,000	Admis- sions into hospital	Ratio per 1,000	Admis- sions into hospital	Ratio per 1,000
Primary syphilis ..	4,992	90·2	6,691	102·6	9,064	129·3
Ulcer of penis ..	..	..	3,987	58·5	5,909	84·3
				161·1		213·6
Secondary syphilis..	1,352	24·4	3,940	57·8	4,316	61·6
Gonorrhœa .. ..	8,070	145·8	10,829	158·9	12,784	182·4
Other venereal dis- eases	1,835	33·2	2,180	32·0	590	8·4
		179·0		190·9		190·8
Total ..	16,249	293·6	27,627	409·8	32,663	466·0

\* Sanitary Report of Commissioners with Government of India, 1899.

# APPENDIX XXVI.

## ARMY OF INDIA.

### “ A COMPARATIVE SUMMARY OF VENEREAL DISEASES IN THE EUROPEAN AND NATIVE ARMIES.” \*

ARMY	1884						1892						1893					
	EUROPEAN TROOPS			NATIVE TROOPS			EUROPEAN TROOPS			NATIVE TROOPS			EUROPEAN TROOPS			NATIVE TROOPS		
	Strength	Admissions	Ratio per 1,000	Strength	Admissions	Ratio per 1,000	Strength	Admissions	Ratio per 1,000	Strength	Admissions	Ratio per 1,000	Strength	Admissions	Ratio per 1,000	Strength	Admissions	Ratio per 1,000
Bengal ..	33,486	9,731	290·6	51,308	1,608	31·3	42,198	17,403	412·4	65,594	2,458	37·5	43,150	19,947	462·3	65,132	2,104	32·3
Madras ..	10,785	3,308	306·7	28,050	635	22·6	13,227	5,489	415·0	25,963	1,182	45·5	13,419	6,448	480·5	26,170	1,149	43·9
Bombay	10,725	3,127	291·6	23,373	750	32·1	12,712	5,035	396·1	23,255	1,159	49·6	13,522	6,268	463·5	23,826	1,167	49·4
India ..	54,996	16,166	293·9	114,827	3,200	27·9	68,137	27,927	409·9	127,355	5,042	39·6	70,091	32,663	466·0	127,091	4,620	36·4

\* Sanitary Report of Commissioners with Government of India, 1899.

## APPENDIX XXVII.

INDIA, 1899.\*

*British Troops.*

ADMISSIONS FOR VENEREAL DISEASE BY COMMANDS. ACTUALS.

Commands	Average annual strength	Primary syphilis	Soft chancre	Secondary syphilis	Gonorrhœa	Venereal diseases, total admissions	Constantly sick in hospital	Admission ratios per 1,000	Deaths from sec. syphilis
Bengal .. ..	21,278	1,423	1,627	1,723	2,992	7,765	716·17	364·9	2
Punjab .. ..	18,080	814	547	883	1,855	4,099	310·99	226·7	3
Bombay .. ..	15,462	923	923	1,085	1,654	4,231	385·87	273·6	1
Madras .. ..	12,876	1,174	1,174	1,175	1,695	5,122	438·28	397·8	7
India .. ..	67,696	4,334	4,271	4,866	8,196	21,217	1851·31	313·4	13
Average duration in hospital of a case in days		35·88	27·72	38·37	28·33	31·89			

\* Sanitary Report of Commissioners with Government of India, 1899.

## APPENDIX XXVIII.

Major Dick, R.A.M.C. (in the *British Medical Journal* of October 2, 1899), gives statistics from the Army abroad, obtained from the Reports of the Army Medical Department. The period taken is from 1880-97.

	Total admis- sions for all diseases in India	Total admis- sions for venereal dis- eases in India	Percentage	Strength of troops in India	Percentage
1880 .. ..	87,616	12,329	14·00	50,136	24·59
1881 .. ..	82,415	13,397	16·25	57,344	23·36
1882 .. ..	92,151	13,136	14·25	58,588	22·42
1883 .. ..	73,847	13,242	17·93	56,190	23·56
1884 .. ..	82,586	14,362	17·39	55,252	25·99
1885 .. ..	87,000	17,580	20·20	57,165	30·77
1886 .. ..	91,630	18,595	20·29	61,757	30·11
1887 .. ..	86,392	16,380	18·96	63,942	25·61
1888 .. ..	94,489	19,427	20·56	68,139	28·52
1889 .. ..	103,119	25,046	24·28	68,545	36·54
1890 .. ..	102,337	25,395	24·81	67,456	37·65
1891 .. ..	91,811	21,005	22·87	66,178	31·74
1892 .. ..	103,870	21,756	20·94	68,045	31·97
1893 .. ..	98,983	26,151	26·42	69,865	37·43
1894 .. ..	106,967	30,995	28·88	70,983	43·66
1895 .. ..	99,766	32,116	32·19	68,331	47·00
1896 .. ..	97,738	31,325	32·05	70,484	44·44
1897 .. ..	96,824	27,268	28·16	64,531	42·25

It will be seen that in the years 1885 and 1886 there was some increase in the proportion of admissions for venereal disease to the total admissions for all diseases, and for the last four years 30 per cent. of all admissions to hospital are for venereal disease. Major Dick further states :—

“The following, I think, however, is satisfactory. The figures are for the years 1882, 1887, 1892, 1897. 1897 is the last year for which statistics are available, and the others are earlier by five years each from the other :—

	Average numbers constantly sick from all diseases	Average number constantly sick from venereal diseases	Percentage
1882 .. ..	3,806·37	910·74	23·66
1887 .. ..	4,505·00	1,200·97	26·65
1892 .. ..	5,707·81	1,766·51	30·94
1897 .. ..	6,541·90	2,543·37	38·71

It will be seen that in 1897, in every hundred sick among the soldiers in India in hospital, and therefore inefficient, thirty-eight were so from venereal disease, whilst in 1882 there were twenty-three, an increase of 15 per cent.

## APPENDIX XXIX.

The following table, the data for which were specially obtained by the Principal Medical Officer, Her Majesty's Forces in India, from the medical officers concerned, and which excludes men on field service, or on the march, distinguishes between the number of admissions and the *number of individual men admitted* into hospital for venereal diseases in 1895 in India.

Average annual strength	No. of men admitted once only	No. of men admitted twice, but not oftener	No. of men admitted three times, but not oftener	No. of men admitted four times, but not oftener	Total No. of men admitted	Total admissions
66,954	21,137	4,620	1,235	496	27,488	36,190

The number of individuals treated was about three-fourths the number of admissions, and the former were in the proportion of 410·6 per 1,000 of strength, the latter of 540·5.

For every 10 men in the army affected by venereal disease there were about 14 free from the same; or, in other words, in every 1,000 men 411 were diseased and 589 exempt.

## APPENDIX XXX.\*

## INDIA.

*Invaliding Ratios per 1,000 of Strength, 1897.*

Syphilis and Gonorrhœa	..	..	..	..	..	..	9·65
Debility	..	..	..	..	..	..	2·62
Malarial Fevers	..	..	..	..	..	..	2·41
Tubercle of the lungs	..	..	..	..	..	..	1·94
Valvular disease of the heart	..	..	..	..	..	..	1·30
Dysentery	..	..	..	..	..	..	1·17
Rheumatism	..	..	..	..	..	..	1·11
Disordered action of the heart	..	..	..	..	..	..	1·10

\* Sanitary Report of the Commissioners with the Government of India, 1899. The above should be contrasted with the Reports for later years (control in force, 1898-1907).—H. C. F.

## APPENDIX XXXI.

The following table, compiled from the departmental report of the Army Medical Department, is introduced to compare the venereal ratio of India with the ratios of other British possessions:—1893—*Venereal Disease*. Admission ratio per 1,000.

England	..	..	..	104·6	South Africa	..	..	..	255·7
Gibraltar	..	..	..	306·5	Mauritius	..	..	..	159·7
Malta	..	..	..	157·5	Ceylon	..	..	..	295·2
Cyprus	..	..	..	185·5	China	..	..	..	380·5
Canada	..	..	..	97·1	Straits	..	..	..	356·4
Bermuda	..	..	..	43·9	India	..	..	..	458·3*
Barbados	..	..	..	402·1	Egypt	..	..	..	408·3
Jamaica	..	..	..	190·0					

\* Excluding "other venereal diseases" and men on field service, to make it comparable with the other ratios in the table.

APPENDIX XXXII.

COMPARISON OF THE "INCIDENCE" OF VENEREAL DISEASES IN EUROPEAN ARMIES.

	ADMISSIONS PER 1,000 STRENGTH				
	German	French	Austrian	Italian	British
1886 to 1890 (average, annual)	27·1	51·1	65·3	94·3	212·4
In 1900 .. .. .	17·8	37·2	59·8	89·7	93·4

Advisory Board Report on "Venereal Diseases in the Army" (1st Report, 1904).

APPENDIX XXXIII.

METHOD OF RECORDING TREATMENT.\*

In the Military Hospital at Rome the medical officer in charge of the skin and venereal division kept a *daily record* of the treatment of each case in his wards on the form shown below :—

MONTH—MARCH—REGISTER OF SYPHILIS CASES.

No. of bed	Name	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	&c.
1	C. G., 20.1.04, 30 F	S	S	F	F	F	S	S	S	CI				
2	T. A., 15.2.04, 10 I	I	I	I	S	S	S	V						
3	A. T., 1.1.04, 10 CI	PI	PI	PI	PI	S	S	S						
4	A. B. .. ..			F	F	F	F	F	S	S	F	F	F	

A fresh form is used for each month : the number of the bed being printed, the name of the man who occupies the bed filled in opposite this. Cases which have remained in hospital from a previous month have the date of their original admission and previous treatment placed opposite their names. The letters filled in have the following meanings :—

- S = Suspensio, *i.e.*, no treatment.
- F = Frictio, *i.e.*, inunction.
- I = Sublimate injection.
- CI = Calomel injection.
- PI = Potassium iodide.
- V = Discharged.

Cases of gonorrhœa are recorded in a similar way.

\*ADVISORY BOARD REPORT ON VENEREAL DISEASES IN THE ARMY.  
(3rd Report, 1905.)

A "Gonorrhœal Case-sheet" (Appendix XL.) has been kept at Royal Herbert Hospital, Woolwich, 1905-07, in addition to Syphilis Case Sheets (Appendix XXIII).  
—H. C. F.

APPENDIX XXXIV.\*

INDIA.

STATEMENT SHOWING NUMBER OF ADMISSIONS AND DISCHARGES FOR VENEREAL DISEASE IN THE CONTAGIOUS DISEASES WARD FOR WOMEN, MHOW, AT A TIME OF STRESS.

*From May 1, 1900, to May 28, 1900, Four Weeks.*

The good effect of control is evident in the “Report of Sanitary Commissioners with Government of India.”

	1ST WEEK From May 1—7				2ND WEEK From May 8—14				3RD WEEK From May 15—21				4TH WEEK From May 22—28			
	Remained	Admitted	Discharged	Remaining	Remained	Admitted	Discharged	Remaining	Remained	Admitted	Discharged	Remaining	Remained	Admitted	Discharged	Remaining
Primary syphilis	1	..	..	7	7	4	..	11	11	5	3	13	13	2	3	12
Secondary ,,	3	2	1	4	4	..	..	4	4	..	1	3	3	2	1	4
Gonorrhœa ..	5	..	1	4	4	1	1	4	4	1	..	5	5	2	..	7
Soft chancre ..	8	..	2	6	6	5	2	9	9	..	..	9	9	5	1	13
Wart .. ..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	1
Total .. ..	17	2	4	21	21	10	3	28	28	6	4	30	30	12	5	37
Famine stricken	..	..	..	..	..	5	..	..	..	5	..	..	..	5	..	..

\* Compiled by writer.

APPENDIX XXXV.

(Army Medical Regulations—Appendix 7.)

INSTRUCTIONS REGARDING PROCEDURE IN CASES OF SYPHILIS, 1904.\*

The scheme outlined in the Memorandum accompanying this office letter 4800/6/1441 A.M.D., 2, dated September 10, 1903, was issued tentatively, with a view to its ultimate adoption should report as to its working justify such a course. The reports received have been favourable, and it has accordingly been decided to continue the scheme with certain modifications which experience has shown to be desirable.

The following instructions are now circulated for general information, and it is directed that the procedure indicated should be taken into use at all stations.

\* Vide Preface.

Dealing as we have to do with garrisons liable to constant change, it follows that there are many obstacles in the way of framing a scheme comprehensive enough to meet every possible contingency. It may be, therefore, that some points are not fully provided for, but the Director-General believes that, with the exercise of initiative on the part of the individual Medical Officer, insurmountable difficulties are unlikely to be met with. Bearing in mind the desirability of uniformity in procedure, and having regard to the importance of thorough treatment in cases of syphilitic disease, not only in the interests of the patient, but also in the interests of the State, Medical Officers are asked to use every endeavour to ensure the successful working of the scheme in all its details. Difficulties may be encountered as regards securing the regular attendance of men, and also probably sometimes in obtaining the man's consent to undergo a prolonged course of treatment, but the Director-General is sure that with due exercise of tact, and careful explanation to patients, such difficulties can be overcome.

#### DIAGNOSIS OF PRIMARY VENEREAL SORES.

It not infrequently happens that a sore, presenting all the characters of a soft chancre, is followed by a constitutional infection, and the converse is also true. In a considerable number of cases the character of the sore can only be settled by watching for the appearance or otherwise of constitutional symptoms. This difficulty leads to error, if a too early attempt at diagnosis be made, as witness the frequency with which we see several entries for primary syphilis in the same medical history sheet, and often without any evidence at all of secondary syphilis having followed. The Director-General desires that Medical Officers will exercise care in the diagnosis of venereal sores, and that they will only return cases as syphilis when no doubt exists as to the nature of the disease.

When the nature of the sore is doubtful, but the Medical Officer thinks that he ought to prescribe a short course of mercury, he may do so, but a case of this kind should not be placed on the Syphilis Register, or returned as syphilis, unless or until constitutional signs of the disease develop. Should the latter fail to appear within a reasonable period, say two months, the case will be returned as one of soft chancre.\* In the event

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\* Three and a half to four months from date of exposure to infection is the safer limit, whether double infection, or otherwise.—H. C. F.

of syphilis manifesting itself at a later period presumably the case must have been one of double infection, and the subsequent syphilis should be dealt with as disease supervening.

After careful consideration of the replies sent in by Medical Officers in connection with the working of the experimental scheme, it has been decided that the proposed Primary Venereal Sores Register is not required, and that the object aimed at by having such a register, namely, the more accurate diagnosis of primary venereal sores, will be equally well obtained by entries in the Admission and Discharge Book.

The following rules will be observed in diagnosing and returning venereal sores.—

(1) Cases admitted with venereal sores will be entered in the Admission and Discharge Book, and the disease column will be filled in "Venereal Sore" in pencil, until such time as the medical officer has made a definite diagnosis, when this will be entered in ink.

(2) Cases which have to be transferred from one station to another, before the diagnosis of the sore has been established, will be notified to and kept under observation at the new station, and the diagnosis, when made, will be communicated to the original station.

(3) In the Annual Return the cases will be classified as "soft chancre" and "syphilis" (omitting distinction between primary and secondary syphilis). When the Annual Return is being made up at the close of the year a certain number of cases may remain undiagnosed, but the return need not be delayed on that account, as stations can send slips to the Principal Medical Officer showing the ultimate diagnosis. These slips must be transmitted to the Principal Medical Officer not later than February 14 in each year.

(4) Cases diagnosed syphilis will be entered in the "Syphilis Register" for a course of continued treatment.

(5) In the Monthly Return, when cases remain undiagnosed at the end of the month, a note will be made as follows:—

Of the N.Y.D. cases.....are venereal. In the succeeding Monthly Return the following note will be made:—

Of the venereal cases remaining last month.....are now shown as syphilis.....as soft chancre, and..... remain N.Y.D. venereal

## SYPHILIS REGISTER.

The purpose of this register is to secure continued treatment for every case of syphilis, and to ensure that the courses of treatment are carried out in a definite and systematic manner.

It is also thought that the register will assist the medical officer to check the attendances of men under treatment, and that it will furnish, in a simple and readily available form, the information asked for in the Medical Transactions of the Annual Return.

The following rules will be observed in keeping the register :—

(1) Every case diagnosed “syphilis” will be entered in the register.

(2) No name is to be removed until the patient has undergone a full course of treatment. Should any special reason arise to prevent this procedure being systematically carried out, the Principal Medical Officer will be notified and a full explanation given.

(3) Transfers from other stations will be entered in red ink with a “T” in place of the serial number.

(4) In the case of a man who is already on the register, and who has been discharged to attend for treatment outside, but who may happen to require re-admission on account of the occurrence of symptoms necessitating hospital treatment, a red ink “R” should be placed in the column of remarks in the syphilis register; should he require a second re-admission a second red ink “R” may be added. In this way a record of re-admissions for syphilis will be obtained in a form which should permit of the totals being readily ascertained at the end of the year. The register may also be the means of enabling reliable data to be obtained as to the efficacy of different methods of treatment, the proper length of time during which treatment should be maintained in an average case, &c. These and other points, which up to the present time have not been determined, should be, with the co-operation of Army Medical Officers, to a great extent cleared up.

(5) Many Medical Officers have asked that a definite ruling should be given as to the minimum period during which treatment should be kept up. After a careful consideration of the available evidence, the Director-General wishes that treatment should be continued for at least twelve months after the disappearance of active signs of the disease, and that, if possible, cases should be kept under observation for a year after that.

(6) A special case-sheet has been drawn up, and will be kept for every case of syphilis. It will bear the same serial number as that given to the case in the register.

SYPHILIS CASE-SHEET.

(*Vide* APPENDIX XXIII.—AMENDED CASE-SHEET.)

Serial number in Register.....Station .....

Regt. No. ....Rank and name.....Corps.....

(1) Probable date and place of infection.....

(2) Date of appearance of sore .....

(3) Character of sore.....

(4) Treatment (if any) before being placed on the Syphilis Register.. ..

.....

(5) Date of being placed on the Syphilis Register.....

(6) Condition at that time as regards—Weight.....

Urine .....Skin .....

Mucous membranes.....Lymphatic glands.....

Other symptoms.....

Treatment and Progress. (The weight should be noted at regular intervals, any constant decrease being an indication to suspend treatment. Changes of station, re-admissions to hospital, and alterations of treatment, with dates, should be noted. The dates and doses of mercurial injections should be given.)

Date.....

THE SPECIAL CASE-SHEET.

As it has been recognised that taking every case of syphilis would, in large stations at least, add very considerably to the work, a special case-sheet has been prepared with the object of lessening clerical labour as far as possible. All headings, dates and such entries as do not require special professional knowledge *may be filled in by the wardmaster or orderly from the Medical Officer's dictation at the time when the case is seen.*

The following rules will be observed :—

- (1) The special case-sheet will be retained by the Medical Officer who is treating the case.
- (2) When treatment has been completed, it will be retained in the Station Hospital, in which the man would be treated if

SYPHILIS REGISTER.

Serial number of case	Corps	Regimental number	Rank and name	Date of being placed on this Register	Date on which constitutional treatment commenced	Drug used, in what form administered	NUMBER OF DAYS UNDER TREATMENT		DATE OF BEING STRUCK OFF THE REGISTER AS		Remarks. Station to which transferred and date. "R" placed in this column
							In hospital	Out of hospital	Transfer to other stations	On completion of treatment	
1	2nd Bn. King's Royal Rifles	4,509	Private Atkins, T...	7.1.04	1.1.04	Hydrar. in pill; later injections hydrar. cream	45	548	..	1.6.05	R. R.
2	45th Battery Royal Field Artillery	123,059	Bmdr. Thomas, A.	15.1.04	15.1.04	Hydrar. inunction. Cream injections when an out-patient	40	548	..	15.6.05	
T	2nd Bn. South Wales Borderers	45,093	Corporal Smith, T.	20.1.04	1.12.03	Hydrar. by mouth. Calomel vapour baths. Hydrar. ch. mixture	90	670	..	1.10.05	R. R. R. Severe case

sick, for a further period of one year. At the end of this time, if the man has remained free from symptoms of syphilis, or has in the meantime become non-efficient, the case-sheet will be sent to the War Office for disposal.

(3) A note will be made in the medical history sheet, "Syphilis," giving dates of placing on and striking off the register; the former will be entered by the Officer placing the case on the Syphilis Register, the latter by the Officer striking the name off on completion of treatment.

(4) If a relapse should occur at a later date, information to that effect will be sent to the War Office, giving the station and date of origin (the latter to enable the case to be traced). When the case has been disposed of, or when the necessary course of treatment has been completed, a case-sheet giving the additional particulars should be sent to the War Office for attachment to the original case-sheet.

(5) When a man is transferred, the special case-sheet will be sent to the Medical Officer at the new station, no other notice being required.

FORM TO BE USED BY MEDICAL OFFICERS FOR COMMUNICATING WITH EACH OTHER, OR OFFICERS COMMANDING UNITS, REGARDING THE ATTENDANCE OR DIAGNOSIS OF MEN UNDER OBSERVATION OR CONTINUED TREATMENT FOR SYPHILIS.

*To be printed on a quarter sheet of white foolscap.*

RETURN OF A SOLDIER UNDER MEDICAL SURVEILLANCE FOR VENEREAL DISEASE.

Corps	Company	Regimental No.	Rank and name	Remarks

To... ..

Station and date.....

.....

The Officer who places the man under surveillance will prepare this form in duplicate. One form will be forwarded to the Officer Commanding, and the other to the Medical Officer who will have the surveillance of the man. When a man under surveillance is transferred to another station, his Commanding Officer will apprise the Medical Officer of the fact. [*Vide* Appendix XXXVI., Amended Return A.F. I. 1239. H. C. F.]

## RETURNS.

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### *Admission and Discharge Book.*

Admissions to hospital will be entered in the Admission and Discharge Book as formerly.

### *Annual Return.*

Admissions for soft chancre and syphilis will be returned as formerly in Table 1 of the Annual Return, except that in the case of syphilis no distinction will be made between primary and secondary forms of the disease.

### *Medical Transactions—Annual Return.*

The following information will be given along with the usual notes on venereal disease :—

(1) The number of cases which have been placed on the register during the year (excluding transfers).

(2) The number of cases coming under treatment as transfers.

(3) The number of cases which have required admission or re-admission while undergoing treatment.

(4) The number of cases which have relapsed after being struck off the Register on completion of a full course of treatment.

With the view of obtaining as accurate data as possible regarding the methods of treatment most in use, the relative value of different methods, and the average duration of treatment of cases of syphilis, it is requested that the information asked for in the following form be given in the medical transactions :—

## METHOD OF TREATMENT.

Placed on Register	Number of Cases	IN HOSPITAL					OUT OF HOSPITAL				
		Mouth	Inunction	Injection	Other methods	Mixed treatment	Mouth	Inunction	Injection	Other methods	Mixed treatment
For the first time .. ..											
As transfers from other stations											

## RE-ADMISSIONS WHILE BEING TREATED BY

Re-admitted	Number of cases	Mouth	Inunction	Injection	Other methods	Mixed treatment
Once .. ..						
Twice . . . .						
Thrice .. ..						
Four or more times						

The object of this table is to obtain, if possible, information as regards the efficacy of different methods of treatment. It is recognised that it will be difficult to obtain accurate information of this kind in all cases, and that it may be impossible in many instances. Medical Officers are, therefore, requested to supply such information as can be depended on. A few cases well observed will be of more value than attempts to give particulars in every case, some of which may be doubtful.

*Average Number of Days under Treatment .....*

In the case of transfers, the average duration of treatment of each case of syphilis will be obtained from the Register by taking the date on which the man was originally placed on constitutional treatment and the date of his being struck off on completion of treatment.

Only cases which have completed their treatment during the year are to be included in this average.

[*Note.*—A copy of these instructions should be in the hands of every Commanding Officer of a Unit, and A.F. I. 1239 be amended to date (*vide* Appendix XXXVI.). Otherwise the frequent movements of men inevitably prevent better results.—H. C. F.]

APPENDIX XXXVI.

Amended Army Form I., 1239.

RETURN OF A SOLDIER UNDER MEDICAL SURVEILLANCE FOR VENEREAL DISEASE.

Corps	Company	Regimental No.	Rank and name	Date on which case originally came under treatment
				Remarks

To... ..  
Station and date.....  
.....

The officer who places the man under surveillance will prepare this form in duplicate. One copy will be forwarded to the Officer Commanding, and the other to the Medical Officer who will have the surveillance of the man.

When any circumstances arise likely to interfere with the regular attendance of men on the continued treatment list, such as transfer to another station, musketry courses, imprisonment, and especially furlough, their Commanding Officer will apprise the Medical Officer of the fact. When cases are transferred Medical Officers will be careful to insert the date on which the case was first placed on a syphilis register, irrespective of the number of registers the case may have passed through.

Forms  
I-1239. January, 1906.  
2

[Remarks.—The Medical Officer should be apprised before the man leaves the station or is transferred to Army Reserve. The soldier inspected on leaving and returning to the station by the Officer in charge of this special work. The address on furlough furnished. Inattention to these details often gives rise to medical unfitness for foreign drafts, &c.—H. C. F.]

## APPENDIX XXXVII.

CIRCUMCISIONS FOR CONGENITAL PHIMOSIS AND VENEREAL DISEASE AT ROYAL HERBERT HOSPITAL, WOOLWICH, IN A PERIOD OF TWO YEARS.

*Average Strength of Garrison, 4,500.*

No.	Name	Date of admission	Date of discharge	Disease	Operation
1	Lce.-Corpl. R.	6.3.05	28.4.05	Syphilis and phimosis	Circumcision, 10.4.05
2	Driver B. ..	6.4.05	1.6.05	" "	" 11.4.05
3	Gunner B. ..	8.3.05	23.5.05	" "	" 11.4.05
4	Pte. W. ..	6.3.05	27.5.05	Phimosis and venereal	" 11.4.05
5	" L. ..	24.3.05	1.7.05	Syphilis and phimosis	" 11.4.05
6	Sergt. M. ..	10.4.05	29.6.05	Phimosis and venereal	Incision, 13.4.05
7	Driver N. ..	20.6.05	28.9.05	Phimosis .. ..	" 24.6.05
8	Br. C. ..	11.7.05	30.5.05	Soft chancre .. ..	Circumcision, 20.4.05
9	Driver M. ..	2.6.05	27.6.05	Phimosis .. ..	" 27.4.05
10	Gunner O'B.	13.7.05	29.7.05	Phimosis with warts	Circumcision and excision, 27.4.05
11	Br. S. ..	25.7.05	18.12.05	Phimosis with ulcers	
12	Pte. B. ..	17.4.05	30.9.05	Phimosis and venereal	Circumcision, 8.6.05
13	" W. ..	31.3.05	27.6.05	" "	" 8.6.06
14	Sergt. M. ..	10.4.05	29.6.05	" "	" 11.5.05
15	Br. M. ..	9.5.05	24.6.05	Syphilis and phimosis	" 11.5.05
16	Lce.-Corpl. B.	12.4.05	24.6.05	" "	" 15.5.65
17	Pte. T. ..	20.4.05	22.6.05	Phimosis and venereal	" 18.5.05
18	Driver S. ..	15.5.05	17.6.05	" "	" 18.5.05
19	Pte. H. ..	13.2.05	14.8.05	" "	" 25.5.05
20	Br. M. ..	9.5.05	24.6.05	Syphilis and phimosis	" 25.5.05
21	Pte. G. ..	12.4.05	20.7.05	Phimosis and venereal	" 11.6.05
22	" W. ..	17.6.05	30.8.05	" "	" 24.6.05
23	Br. W. ..	4.8.05	25.8.05	Chancre and phimosis, and bubo	" 10.8.05
24	Gunner F. ..	3.8.05	30.8.05	Chancre and phimosis	" 10.8.05
25	" W. ..	23.8.05	12.9.05	Phimosis and venereal	" 24.8.05
26	Driver C. ..	9.8.05	13.12.05	Soft sore, phimosis ..	" 6.9.05
27	" P. ..	7.9.05	24.10.05	Phimosis .. ..	" 29.9.05
28	Pte. F. ..	25.9.05	1.1.06	Phimosis and venereal	" 29.9.05
29	Gunner M. ..	18.10.05	2.1.06	" "	" 4.11.05
30	" N. ..	29.12.05	9.4.06	V.S. and phimosis ..	" 1.1.06
31	" W. ..	19.1.06	13.2.06	Phimosis .. ..	" 23.1.06
32	Pte. D. ..	13.2.06	21.3.06	Phimosis and chancre	" 15.2.06
33	Br. P. ..	3.1.06	17.3.06	Gonorrhœal warts and phimosis	" 15.2.06
34	Driver H. ..	12.2.06	4.5.06	Phimosis and venereal	" 5.3.06
35	Gunner S. ..	22.5.06	12.6.06	Phimosis .. ..	Circumcision (partial), 24.5.06
36	Sergt. D. ..	20.10.06	22.12.06	Balanitis and phimosis	Circumcision, 22.11.06
37	Pte. B. ..	5.11.06	11.12.06	Gonorrhœa and phimosis	" 27.11.06
38	R.-R. H. ..	22.10.06	26.1.07	Syphilis and phimosis	" 29.11.06
39	Corpl. H. ..	22.9.06	17.11.06	V.S. and phimosis ..	" 3.12.06

APPENDIX XXXVII.—*Continued.*

CIRCUMCISIONS FOR CONGENITAL PHIMOSIS AND VENEREAL DISEASE AT ROYAL HERBERT HOSPITAL, WOOLWICH, IN A PERIOD OF TWO YEARS.

*Average Strength of Garrison, 4,500.*

No.	Name	Date of admission	Date of discharge	Disease	Operation
40	Lce.-Corpl. N.	22.10.06	29.12.06	Gonorrhœa and phimosis	Circumcision, 5.12.06
41	Pte. B. ..	21.11.06	28.1.07	Syphilis and phimosis	„ 10.12.06
42	Driver B. ..	26.11.06	20.4.07	„ „	„ 10.12.06
43	„ B. ..	12.12.06	23.2.07	V.S. and phimosis ..	„ 21.12.06
44	„ B. ..	13.12.06	5.2.07	„ „	„ 29.12.06
45	„ R. ..	26.12.06	2.2.07	„ „	„ 3.1.07
46	Gunner C. ..	14.1.07	8.3.07	„ „	„ 19.1.07
47	Driver P. ..	1.1.07	22.2.07	„ „	„ 21.1.07
48	„ A. ..	4.2.07	6.4.07	Gonorrhœa and phimosis	„ 6.2.07
49	Gunner M. ..	12.3.07	22.5.07	V.S. and phimosis ..	„ 14.3.07
50	Pte. D. ..	16.2.07	5.6.07	„ „	„ 4.4.07
51	„ B. ..	5.4.07	5.6.07	„ „	„ 8.4.07
52	Gunner B. ..	3.4.07	25.5.07	„ „	„ 15.4.07
53	Driver A. ..	4.4.07	13.5.07	Syphilis and phimosis	„ 15.4.07
54	Boy B. ..	3.4.07	22.5.07	Gonorrhœa and phimosis	„ 29.4.07
55	Gunner C. ..	29.4.07	17.6.07	Gonorrhœa and V.S., and phimosis	„ 23.5.07
56	Driver F. ..	2.5.07	9.8.07	Balanitis and gonorrhœa, and phimosis	„ 28.5.07
57	Pte. T. ..	16.4.07	18.7.07	„ „	„ 29.5.07
58	Gunner S. ..	22.4.07	30.7.07	Gonorrhœa and phimosis	„ 4.6.07
59	„ B. ..	9.4.07	25.6.07	Syphilis and phimosis	„ 7.6.07
60	Driver M. ..	17.4.07	22.6.07	„ „	„ 10.6.07
61	„ C. ..	15.6.07	22.8.07	„ „	„ 22.6.07
62	„ C. ..	3.6.07	23.7.07	V.S. and gonorrhœa, and phimosis	„ 22.6.07
63	„ S. ..	11.6.07	17.7.07	Syphilis and phimosis	„ 26.6.07
64	Gunner G. ..	4.6.07	29.7.07	V.S. and phimosis ..	„ 26.6.07
65	Pte. C. ..	10.1.07	3.8.07	Gonorrhœa and phimosis	„ 26.6.07
66	Driver S. ..	27.6.07	16.8.07	V.S. and phimosis ..	„ 3.7.07
67	Gunner N. ..	3.7.07	6.8.07	Gonorrhœa and phimosis	„ 13.7.07
68	„ L. ..	15.7.07	13.8.07	„ „	„ 17.7.07
69	Driver L. ..	13.7.07	22.8.07	V.S. and phimosis ..	„ 17.7.07
70	„ W. ..	17.7.07	23.8.07	V.S. and gonorrhœa, and phimosis	„ 20.7.07
71	Pte. L. ..	22.7.07	21.8.07	Gonorrhœa and phimosis	„ 22.7.07
72	„ L. ..	19.7.07	31.8.07	Syphilis and phimosis	„ 22.7.07
73	Driver S. ..	18.7.07	26.8.07	Gonorrhœa and phimosis	„ 25.7.07

## REMARKS.

The above only partially represents the inefficiency at one large Military Station owing to the enlistment of men with an easily remediable condition, viz., congenital phimosis, who subsequently contract venereal disease and have to be later operated on under extremely unfavourable conditions, necessitating a very long stay in hospital. If recruits were refused until the phimosis had been first remedied by circumcision at a civil hospital a vast amount of time (and consequently money) spent in military hospitals in all parts of the world could be saved. It is an important matter and requires careful consideration. Further, the operation of circumcision unquestionably protects against contracting syphilis.—H. C. F.

## APPENDIX XXXVIII.

## “INSTRUCTIONS FOR GONORRHŒA CASES.”

The following tabulated rules form a rough general guide, reduce clerical labour, and simplify ward work in dealing with large numbers of gonorrhœa cases with a small staff. A copy can be posted in a conspicuous place in the ward.

(1) All cases on admission will have two No. 9 pills, and later mist. alba,  $1\frac{1}{2}$  ozs., every morning for seven days, or until the treatment is changed by the medical officer in the book.

(2) Mist. alkaline, 1 oz., t.d.s., for ten days, or until the treatment is changed by the medical officer in the book. If there is much scalding, or chordee, the medicine can be given every four hours, and a hot bath twice daily.

(3) No injection, or irrigation, until ordered in the book by the medical officer.

(4) Bed, except for necessary purposes, until marked “up” by medical officer. This includes absolute exemption from hospital fatigues.

(5) A piece of clean lint, or cotton-wool, soaked in 1 in 2,000 perchloride of mercury, will invariably be kept on the penis between the glans and foreskin, changed frequently and placed in a special basin.

(6) The patient must be careful that he does not touch his eyes with the discharge, or he may lose his sight.

(7) Under no circumstances will a patient with pain in the

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\* “Treatment of Gonorrhœa in the Army,” *Journal of Royal Army Medical Corps*,” June, 1907. Major H. C. French.

testicles, or groin, or with swollen testicles, inject or be irrigated, except with the medical officer's permission. The orderly carrying out irrigations should be so warned (*vide* Appendix XXXIX.).

(8) Cases of *relapse* of gonorrhœa re-admitted to hospital will be recorded as such on their diet sheets in red ink, with the date of their previous stay in hospital, and enquiry elicited as to "the cause."

(9) Cases of gonorrhœal complications, such as epididymo-orchitis, arthritis, stricture, &c., should be entered in red ink on the diet sheet, and on a "gonorrhœal case-sheet" (Appendix XL.), which is filed for reference.

(10) Two hip baths are kept in the ward for "acute" cases of gonorrhœa, or cases with swollen testicles, specially ordered hot baths. The bath daily used by "convalescing" gonorrhœal cases will be indicated in the bathroom by a notice board.

(11) The wardmaster, or orderly, in the ward, will read the above orders to each patient on admission.

*Royal Herbert Hospital,  
Woolwich.*

H. C. FRENCH,  
*Major, R.A.M.C.*

The above rules are framed to guard against initial neglect in the *acute* stage by the patients, or orderly, since inattention to minutiae is ordinarily a common cause of epididymo-orchitis, &c., and of a prolonged stay in hospital (eight to twelve weeks).

I consider that cases of gonorrhœa in hospital should be marked "bed" during the "acute" stage, that is, about seven to twelve days. Milk or "farinaceous" diet, with barley water, porridge, and cocoa as extras. During this period, free saline purgatives are administered every morning, and mist. alkaline. This dietetic and sedative line of treatment usually prevents chordee and pain, and better guards against "systemic" infections, such as myalgia, septicæmia, and gonorrhœal rheumatism with or without effusion, and protects against intractable complications, such as prostatitis and epididymo-orchitis, due to backward extension. After ten days, on an average, under this treatment, the formerly creamy, yellow, purulent discharge becomes thinner, whiter, and muco-purulent. The man may then be marked "up" and his diet changed to convalescent. Alcohol, spices and much meat prolong the duration of the discharge, which, in uncomplicated cases, ordinarily lasts five to six weeks, when carefully treated in hospital and inspected on discharge.

## APPENDIX XXXIX.

## IRRIGATION—GONORRHOEA CASES.

(1) Urine flasks are to be numbered 1 and 2 on neck of bottle. The “*first*” morning urine of each man will be passed, first half into No. 1 urine flask and the second half into No. 2 urine flask. The Medical Officer inspects the urine flasks at his visit and they are to be washed out at 11.30 a.m., but not used again until the following morning. (*Vide* Appendix XL. footnote.)

(2) The orderly doing the irrigations will take the Medical Officer’s instructions from the “Gonorrhœal Case-Sheet” for each patient, which is kept with the Diet-Sheet. Before commencing each irrigation, he will ask the patient whether there is any pain, or inconvenience, caused by the irrigation, and will see that he first passes urine. Patients with acute gonorrhœa are not irrigated for four days, and during this period can *gently* syringe themselves every hour with warm water.

(3) *Anterior* irrigation is for the anterior part of the urethra and does not enter the bladder. Permanganate of potass., grs. ii. to the pint, at a temperature of 98° F., is to be used three times daily at 6.30, 11 a.m. and 2 p.m. The quantity used is one pint of potass. permang. solution, grs. ii. to Oi. *Posterior* irrigation enters the bladder, and before allowing it to do so the anterior urethra must be first washed out with half a pint of the potass. permang. solution, grs. ii. to Oi., at a temperature of 98° F.; half a pint of the same solution is passed into the bladder. The patient, after receiving the irrigation, empties his bladder into a glass and shows it. Posterior irrigation is only done once a day, but two anterior irrigations are to be given in addition.

(4) The large glass irrigator is placed about 4 feet above the level of the chair on which the patient sits. The glass nozzle of the irrigator is to be sterilised before use, and must be disinfected between each case by dipping it in 1 in 20 carbolic. Extra care is to be taken with patients suffering from syphilis and gonorrhœa. The orderly will use india-rubber gloves.

If specially ordered, silver nitrate, grs. ii. to Oi., or zinc sulphate, grs. ix. to Oi., may be used for irrigations.

Royal Herbert Hospital,  
Woolwich.

H. C. FRENCH,  
Major, R.A.M.C., in Charge  
Venereal Wards.

## APPENDIX XL.

## GONORRHOÆAL SHEET.\*

Reg. No. :	Rank and Name : Private A.		Corps	
Admitted to Hospital, 1.1.07.      Discharged :				
Date	Anterior urethra	Posterior urethra	Treatment	Remarks
1.1.07	Urine cloudy†	Urine clear†	Anterior irrigations	Mist. alkalini three times daily. Hot bath twice daily  H. C. FRENCH, Major, R.A.M.C.

\* In use at Woolwich—I first used a special “Gonorrhœal Case-Sheet” at Kamptee, India, in 1900.—H. C. F.

† *Vide* Appendix XXXIX. (1) and (2). Care must be taken to prevent the patient tampering with his urine by adding water in order to deceive the Medical Officer as to the real state of his urine. The specific gravity will usually give a clue.—H.C.F.



# APPENDIX XLI.

UNITED KINGDOM, 1886 TO 1895.\*

District	STRENGTH		AVERAGE CONSTANTLY SICK				Esti- mated number of beds required	Per- centage of venereal beds to strength	Ratio of venereal beds to strength. One venereal bed for	Approxi- mate decrease in venereal per- centage	Number of beds esti- mated, multi- plied by (.71) the factor of decrease for the United Kingdom
	Average annual	Primary syphilis	Soft chancere	Secondary syphilis	Gonor- rhoea	Total venereal					
Northern {	10,267	43	16	28	59	147	152	1.48	70	25	108
North-eastern {											
Eastern ..	5,432	26	10	19	34	90	92	1.69	60	16	65
Western ..	6,697	38	20	20	42	120	126	1.88	53	—	89
Thames ..	4,111	24	2	13	21	60	62	1.50	66	—	44
Southern ..	8,444	52	22	43	55	172	173	2.05	49	—	122
South-eastern ..	7,452	39	3	25	36	103	103	1.38	72	45	73
Home ..	7,516	81	7	36	67	191	200	2.66	37.5	—	142
Woolwich ..	5,753	40	12	23	40	115	110	1.91	52	—	78
Aldershot ..	14,078	107	25	56	84	272	278	1.97	50.6	—	197
Channel Isles ..	1,643	8	2	6	11	28	29	1.76	56.6	—	20
Dublin ..	8,330	58	13	31	66	169	177	2.12	47	39	125
Cork ..	8,423	18	6	13	34	72	75	0.89	112	30	53
Belfast ..	3,801	19	5	9	18	52	54	1.42	70	10	38
Scottish ..	3,621	9	5	7	14	35	35	0.96	103	—	25
Curragh ..	4,325	25	7	11	20	63	66	1.52	65	29	47
United Kingdom ..	99,893	587	155	340	601	1,689	1,732	Average 1.65	Average 64.2	—	1,226

This complete period of ten years was selected as the figures were available from Netley.

Note 1.—The number of “Beds required” has been arrived at by deducting half the average of secondary syphilis from the average total venereal constantly sick, and adding 15 per cent. for fluctuation.

Note 2.—The percentage decrease shown is only roughly approximate and cannot be used to base calculations on.

Note 3.—From 1896 to 1899 the average venereal constantly sick = 12.09 per 1,000. Dividing 16.8 into 12.09 we get 0.71 as the factor of decrease for the United Kingdom.

\* Advisory Board, 1st Report, 1904, “Venereal Diseases in the Army.”

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